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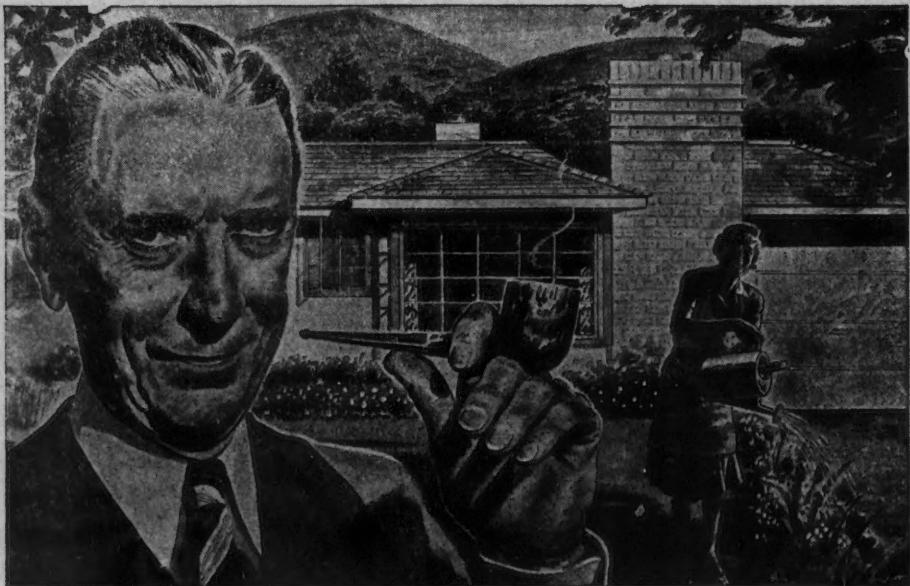
QUARTERLY



THE CHICAGO MEDICAL SCHOOL

VOLUME 7, NUMBER 1

DECEMBER, 1945



Let your HEAD take you

(The average American today has a choice of just going where "his feet take him", or choosing wisely the course to follow. Let's skip ahead 10 years, and take a look at John Jones—and listen to him . . .)

"**S**OMETIMES I feel so good it almost scares me. This house—I wouldn't swap a shingle off its roof for any other house on earth. This little valley, with the pond down in the hollow at the back, is the spot I like best in all the world.

"And they're mine. I own 'em. Nobody can take 'em away from me.

"I've got a little money coming in, regularly. Not much—but enough. And I tell you, when you can go to bed every night with nothing on your mind except the fun you're going to have tomorrow—that's as near Heaven as man gets on this earth!

"It wasn't always so.

"Back in '46—that was right after the war and sometimes the going wasn't too easy—I needed cash. Taxes were tough,

and then Ellen got sick. Like almost everybody else, I was buying Bonds through the Payroll Plan—and I figured on cashing some of them in. But sick as she was, it was Ellen who talked me out of it.

"'Don't do it, John!' she said. 'Please don't! For the first time in our lives, we're really saving money. It's wonderful to know that every single payday we have *more* money put aside! John, if we can only keep up this saving, think what it can mean! Maybe someday you won't have to work. Maybe we can own a home. And oh, how good it would feel to know that we need never worry about money when we're old!'

"Well, even after she got better, I stayed away from the weekly poker game—quit dropping a little cash at the hot spots now and then—gave up some of the things a man feels he has a right to. We didn't have as much fun for a while but we paid our taxes and the doctor and—we didn't touch the Bonds.

"What's more, we kept right on putting our extra cash into U. S. Savings Bonds. And the pay-off is making the world a pretty swell place today!"

*The Treasury Department acknowledges with appreciation
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THE CHICAGO MEDICAL SCHOOL

QUARTERLY

Published Quarterly Under the Auspices of

THE CHICAGO MEDICAL SCHOOL

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Editorials . . .

OUR NEW TRUSTEES

It has long been said that "an army is only as good as its commanders." Perhaps the analogy that "a medical school is only as good as its trustees" does not follow exactly, but there is little doubt that the governing body of any institution has a great deal to do with the policies and development of that institution.

This month we are happy to announce the appointment of three new trustees, Judge Louis E. Levinthal, Mr. Albert H. Lieberman, and Mr. Mark Sugarman. On pages 20 and 21 of this issue, brief biographical sketches of these men will be found. A rapid glance at the list of their affiliations and activities will reveal at once their diversified philanthropic and humanitarian interests. These men are liberals. They are typical of the members recently appointed to the Board of Trustees of our school. They are men respected in their communities, active in aiding their fellow man and impeccable in their personal and business ethics. They are well qualified to formulate and direct the policies of a school renowned for its unwavering liberalism and detestation of religious and racial prejudice. We of the student body, are intensely desirous that this academic freedom survive even as we progress closer and closer to our goal. We feel confident that under the guidance of men such as these, our present high standards will remain inviolate, so that we may be justly worthy of the approval which must inevitably be ours.

VOCATION VS. AVOCATION

The editor was appalled the other day while perusing the obituary column of *The Journal* of the A.M.A. to observe the tremendous number of deaths of men under 50. Among the chief causes of death were coronary diseases and ruptured or bleeding peptic ulcer. It seems a great tragedy that men who spend

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over 16 years preparing for their profession should live their lives in such a way that they die in the prime of life. The rapid wearying tempo of our modern living has swept them away as readily as it carries off the high-pressure executive, just at that period of life when they could be of most use to humanity and themselves.

The physician is constantly advising his high-strung, over-energetic patient to slow down and relax, yet he very seldom attempts to apply this advice to his own pattern of living. Many of our finest physicians work 12 to 16 hours a day, six to seven days a week without let-up, year after year. Is it any wonder they break down before the half-century mark?

What is the key to a well-rounded, well-balanced existence? What is the safety-valve that releases the steam of excessive strain? The answer lies in a hobby—an avocation. The nature of the hobby is not important; it may be literature, carpentry, stamp-collecting, numismatics, or even breeding canaries (the Editor's own hobby), so long as it is completely different from the practice of medicine. Only those who have hobbies of their own can appreciate the deep satisfaction and complete sense of release afforded by them.

An avocation serves a double purpose. Besides offering a means of relaxation and pleasure, thus diverting the mind from the strains and cares of existence, it serves to round out one's life and creates a broader philosophy of living. Too many physicians become so engrossed in their work that they lose sight of the many other aspects of life. A hobby will help to prevent this.

Physicians must live for themselves as well as their patients. In so doing, they will ultimately serve their patients better. Every physician should attempt to develop his perspective, ability and understanding, and (by leading a well-balanced existence) attempt to lengthen his life-span. An avocation will aid greatly in accomplishing all of these endeavors.



ETHICS OF MEDICAL PRACTICE: BABYLON TO 1945

Sherman Isaacson

AS the world tries desperately to find some means of adjustment of its political and spiritual state to cling to the heels of the onrushing, overwhelming tide of technical advance, it paradoxically fights for survival against forces of self-destruction of its own creation. Every phase of human life finds itself inextricably involved in the whirlpool, and struggles for a condition of equilibrium. Medical practice is definitely no exception for spiritual and ethical guides must accompany every new advance of a scientific nature, lest exploitation be its end. Thus it is imperative that we take stock of our position in this dynamic era.

Ethics have always played an important role in the thinking of mankind, but in medicine our position is a distinctive one. For the business of our work is the human being, his body and mind. Human life itself, the ultimate *sine qua non*, concerns us directly. We, therefore, are in a position where moral rigidity is the essence of our approach to practice. But wherein does our problem lie? Fundamentally, as in all ethical problems, the basis of activity may be considered from two lights which are apparently in opposition to each other: that of idealism which stresses the good of humanity as a whole and that of individual interest which refers to the end of personal good. While the consideration of medical etiquette, concerned with the conduct of physicians toward each other, is of the latter nature, that of morality and altruism should be the ultimate goal in the conduct toward individual patients and society as a whole. But this manifest display of humanitarianism is not enough. The will and motive behind this conduct must be considered. Herein arises the basic ethical question of medicine: "If physicians have a pecuniary interest in treating the ills of humanity, can they honestly really desire to see mankind in perfect health?" It is to safeguard both physicians and society from the pitfalls involved in this question, that written medical codes have evolved.

The story of the attempt to regulate the activities and motivations of medical practice begins

with a treatise on this subject written in Babylon in 2700 B.C. The famous Code of Hammurabi, King of Babylon, appeared about 2250 B.C. In this, the "oldest code of laws in the world," is contained the idea of the physician's personal responsibility, and laws about fees and penalties of various sorts.

In the period of Athenian greatness of about 500 B.C., theurgic domination was cast off and the general principles of moral conduct and taste in the practice of the art were formulated. These we have in the "Oath, Law, Precepts, and Decorum" of Hippocrates, the Father of Medicine. The famous oath of Hippocrates, which has served as the traditional basis of deontology for 2000 years up to the present day, has as its chief provisions the following: the physician should (1) call consultants if in doubt, (2) be reasonable in fees and forego them if necessary, (3) lead a pure and moral life, and (4) respect and honor his teachers; the physician should *NOT* (1) sanction nor give poison, (2) cause nor encourage abortion, (3) use his position to debauch, (4) divulge any information about a patient professionally or otherwise, (5) advertise in any manner, nor (6) assume ostentation in dress or manner. Practically every great leader in medicine has echoed these admirable principles of the Hippocratic writings, and an *esprit du corps* was established in the profession with the tradition of noble bearing and wholesome personal honor.

But a transition from broad principles to the current complex ethical system developed in the eighteenth century. Men sought detailed and comprehensive laws for every phase of their activity. In medicine this trend was reflected in the famous "Code of Medical Ethics" of Thomas Percival of England. Percival's work is divided into four parts headed: "Of Professional Conduct Relative to Hospital or Other Medical Charities"; "Of Professional Conduct in Private or General Practice"; "Of the Conduct of Physicians to Apothecaries"; and "Of Professional Duties in Certain Cases Which Require Knowledge of Law." This work was completed

in 1803. Something, however, had to be lost in such a transition, for growing in this change was the emphasis on letter instead of spirit, and conflicts in the myriad of rules. Despite Percival's fine intentions such a loss is inevitable whenever a warm, fervent feeling is embodied in cold, calculated stipulations.

Ethical standards were followed and maintained nobly in American medicine up until the early part of the nineteenth century when the rapid national expansion with the accompanying increased demand for medical attention, gave much opportunity for the unscrupulous in the dignified and lucrative profession. Adequate training facilities were not available and the morale of the profession fell to a disgraceful state. At this time several societies developed, to disseminate abridged editions of Percival's codes widely, in an attempt to strengthen the high moral ideals so necessary to the maintenance of medical standards. In this same spirit, Dr. Nathan Smith Davis succeeded in overcoming much opposition by organizing the American Medical Association in New York City in 1846. The chief business of the first meeting was the formulation of minimal requirements for medical training. The derivation of this code from Percival's is acknowledged in the preface. The chapter headings of the national "Code" show the interesting thoughts of the men of the time: "I. Of the Duties of Physicians to Patients and the Obligations of Patients to Their Physicians"; "II. Of the Duties of Physicians to Each Other, and to the Profession at Large"; and "III. Of the Duties of the Profession to the Public and of the Obligations of the Public to the Profession." These reflect an aloofness that might be termed what Sinclair Lewis has called "that amiable contempt called 'poise'." Later work removed this objectionable feature.

After the Civil War, medical education in the United States became very bad and the profession consequently suffered. The situation became very acute and in 1882, the Medical Society of the State of New York offered a simplified and brief substitute for the national code. This met with great opposition by the national organization. As a result, the New York group in the next year abandoned a codified system entirely and based its action on the statement that the only offenses for which the profession should

exercise discipline, are those "comprehended under the commission of acts unworthy a physician and a gentleman." The situation was made even more ridiculous when in the following year a rival New York group was formed, which accepted the national code. Compromises which were inevitable followed, resulting in the 1903 edition of "The Principles of Ethics of the American Medical Association." This was again revised in 1912, 1926, and 1934. Both the original "Code" and the "Principles" have retained much in common with Percival's work.

In considering foundations for medical ethics, it must be borne in mind that no life calling is more exposed to temptations to forget honor, humility, and kindness than the medical profession, and none in which exploitation of human suffering is easier. An unswerving strength of idealism must thus be the permeating consideration leading our deeds into corresponding directions. And yet there is no other field in which such temptations are so steadfastly withstood. In this fact we are proud and rightfully so.

To meet the test of time a system of ethics must have two chief characteristics: principles which meet the every need of the present, and those still so broad as to permit interpretations to be made when changes require. Changes in ethics only occur when a conflict between ethics and conditions develop. As an example, the widening growth of industry with its inherent divisions of income classes grouped in large numbers in concentrated areas, brings proposals of group practice to the fore. In such event, ethical rules must be modified accordingly. The trend of the times cannot be disregarded without untoward repercussions resulting.

The physician of today must make every effort toward correlating his smooth adjustment to the changing world with the maintenance of morality, to retain his rightful position of honor among his fellow men. It is up to the present generation of men of medicine to hold the banner high so that the technical nature of material medicine does not undermine its ethical foundations. To this end must we dedicate our actions. The nourishing fruits of experience in our noble heritage will strengthen us toward further advances

(Continued on page 32)

THE USE OF A NEW ANTI-HISTAMINIC DRUG (BENADRYL) IN ALLERGIC DISEASES

Samuel J. Taub, M.D., F.A.C.P.

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NEWER studies of the allergic diseases during the past few years have emphasized the formation of histamine by sensitized cells and this release of histamine into the blood stream is responsible for many of the symptoms occurring in Urticarias, Serum sickness, Hay Fever, Asthma and allied disturbances. *A brief summary of the mechanism of the hypersensitive reaction, will be stated here so that the reason for the use of this new drug can be better understood.

The individual is first exposed to a foreign protein, which causes the production of specific antibodies. Some of the antibodies produced have the ability to combine with tissue cells and sensitize them. Upon readministration of the antigen, an antibody-antigen combination occurs upon the surface of the sensitized cells leading to the formation of a powerful chemical substance (H-substance) histamine. The H substance histamine or altered cell causes the profound effects observed.

Benadryl (Beta-dimethylaminoethyl benzylidryl ether hydrochloride) is a new synthetic drug which appears to belong to a new and distinct pharmacological group having a specific anti-histamine action. The term anti-histamine is used merely as a descriptive means for designating chemical compounds which have the distinct property of preventing at least some of the pharmacologic actions of histamine on smooth muscle of the bronchioles and intestines of the guinea pig and appears to be more potent in this respect than any compound as yet isolated. It is a white crystalline powder soluble in water and alcohol. The solution may have a slight opalescence and it is stable under ordinary conditions of temperature and atmosphere.

Clinical Considerations:

Benadryl is readily absorbed by all routes of administration, the maximal response to oral administration occurs in about ten to twenty minutes and the effects last for five to eight hours.

The response to parenteral administration manifests itself in three to ten minutes and the effects last four to five hours. The drug can be given intra-muscularly or intravenously. There are no accumulative effects noted and so far no effects of intolerance to the drug have been seen. A few patients have exhibited a mild hypnotic effect with drowsiness lasting about one to one and a half hours.

Dosage Schedule

Fifty mg. orally three of four times a day can be used therapeutically. Children up to twelve years of age can take ten to twenty-five mg. three to four times a day. In a few patients who noticed a persistence of the hypnotic effect smaller doses of twenty-five mg. should be tried.

It is of distinct value in Angio Neurotic Edema, Urticaria, Serum sickness, and Vasomotor rhinitis.

Three patients with severe Angio Neurotic Edema and Urticaria following the use of penicillin and two patients with serum sickness were relieved completely on doses of 50 mg. by mouth four times a day. Within the first twenty-four hours the swelling and itching disappeared and the minor recurrences of Urticaria were controlled with the use of fifty mg. for two doses given during the next twenty-four hours.

Four patients with vasomotor rhinitis of a chronic intractable type were relieved of symptoms after the use of Benadryl in fifty mg. doses every six hours for a three day period. With recurrence of symptoms, one capsule taken at the time of the attack of sneezing and nasal obstruction, relief occurs within a fifteen minute period. No abnormal changes in the blood count or blood chemistry have been noted as yet. Although it is probably too early to make any definite statement as to the possibility of any deleterious action on the blood elements or bone marrow.

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A CLARIFICATION OF SOME DIFFICULT FEATURES IN THE ANATOMY OF THE SOFT SKELETON

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THE majority of organs move within the confines of the body or change periodically in bulk. Many do both. The yielding fibrous and fatty connective tissues that surrounds them, supports them, resists their dislocations, and limits their normal movements may be called the soft skeleton. Its gross anatomy usually puzzles and discourages the student. Its understanding is tied up with the form and movement of the organs which it invests. By the time the organs are revealed by dissection the surrounding connective tissue has partly disappeared. Referring to the soft skeleton in the pelvis, Dr. Jamieson, Professor of Gross Anatomy at the University of Edinburgh, that clear-headed Scotchman regarded by some as the leading modern teacher of the subject, gave council to his students which we may paraphrase in this manner: "You may read descriptions of the gross extra-organic connective tissue structures of the pelvis but it will do you no good. You will know nothing about them when you have finished." We seek to show that methods are available which afford a more hopeful prospect of understanding such structures.

When we first attempted to furnish students with a general introduction to fasciae and other extra-organic connective tissue structures we were surprised to find that texts, while they start students on their way with introductory chapters on bones, joints, muscles and a number of other topics, offer no such aid in this most difficult phase of gross anatomy. Furthermore, no complete scheme of classifying the gross extra-organic connective tissue structures could be found in the texts or the journals. As far as we can find, this statement still holds except for our attempt in this direction published in volume sixty-seven of the *Anatomical Record*. The literature in fact offers a surprising picture of conflicting ideas and terminology.

Back of the confusion of ideas and disagreements of writers lies a long history of the application of inadequate laboratory techniques. This

applies especially to the delicate connective tissue formations of which the sub-cutaneous, sub-peritoneal and other sub-serous layers are made up. These can not be clearly shown by dissections as their grosser elements are collapsed and distorted by the tension and pressure of the dissecting instruments.

Another difficulty confronting the anatomist is poor embalming. We saw at the University of Paris, fifteen years ago, at the beginning of the winter quarter, a hundred bodies to be used for dissection of the viscera. They were "embalmed" only with a saline solution, the low temperature of the laboratory being partially relied upon to hold back decomposition. At about the same time at the University of Rome, Professor Versari explained that the bodies were not embalmed at all but were dissected in two or three weeks with a large number of students working at each table. Fortunately, in this country, a strong embalming solution is usually available.

Another difficulty, as already suggested, is that some of these structures as fascia or panniculus adiposus while extending over a considerable area have a fine, almost microscopical gross structure. Several recent workers have studied rather limited territories with methods on the boundary line between the gross and the microscopical. We have been working with foot-long razor cuts and with photographic records. This method permits a leisurely comparison of the subtle structural difference in a large series of bodies.

We will present some definitions and describe some major groups of extra-organic connective tissue structures apparently not yet recognized except in our previous writing. There is not space for a complete survey nor can we explain the observations, logic or history upon which our suggestions are based.

A fascia is a fibrous sheet containing no grossly visible accumulations of fat cells and paralleling the surface of an organ or group of organs. If

it be at a distance from the organ it is connected to it by one of the firmer types of connective tissues. An example is, the renal fascia which is joined to the kidney by panniculus adiposus. Or, the fascia may be adherent to the organ as the fascia of the pectoralis major muscle. If a fibrous sheet paralleling the surface of an organ has one of several types of very yielding structures between itself and the organ so that the organ can move freely on the sheet then such a covering is a sheath. Examples of sheaths are the fibrous layers of the pericardium and the sheath of the sub-mandibular (sub-maxillary) gland.

A capsule is very different from a fascia or a sheath. It is a fibrous sheet forming an integral part of an organ. It constitutes its outer layer and is continuous with the connective tissue supporting structure of the organ. This has long been appreciated in microscopical anatomy. An example of a capsule is the "true capsule" of the thyroid gland, as surgeons designate it. Another is the epineurium of a nerve. An illustration of a wrong use of capsule is the phrase "Tenon's capsule." This structure is proven functionally to be the sheath of the eyeball by the ease with which the ball moves on it.

The term superficial fascia is used in four different ways by recognized anatomists. We accept the view held by a few that the term should be applied to any fascia located in the subcutaneous layer of the body. All but one writer in the English language, we believe, restricts its territory in the trunk, aside from the perineal region, to the anterior abdominal wall where they call it Scarpa's fascia. We find it in a cross section study on thirty-one male bodies now being concluded that it occurs in both the anterior and lateral wall of thorax and abdomen. It is best developed (about 80%) in the lateral abdominal wall and least (40%) in the anterior thoracic wall. Its presence has also been claimed in the dorsal part of the trunk and in the proximal part of arm and thigh.

Panniculus adiposus is the chief gross connective tissue sheet found in the subcutaneous and subserous layers. Nearly always where there is a fascia in either of these layers the panniculus is tri-laminar and made up of superficial and deep panniculus with a fascia between them. Certainly the superficial panniculus in the abdomen should not be called Camper's "fascia." One reason why

the deeper of these three layers has apparently not been clearly recognized in the anterior abdominal wall by any writer in the English language is that it has been a frequent practice to pick wasted or at least thin bodies when demonstrating superficial ("Scarpa's") fascia by dissection. In the wasted bodies deep panniculus has lost more or less of its fat and its fibrous elements are collapsed together so that they seem a part of the superficial fascia. In thin but not wasted bodies dissection is not adequate to demonstrate the delicate deep panniculus which frequently in them as shown by our razor cuts is only two millimeters in thickness. In bodies of greater adiposity deep panniculus may be two centimeters thick.

The adjective deep as applied to muscular fascia is inaccurate and confusing as it implies from the view point of the total body that these are the deepest fasciae. In fact the deepest fasciae are those situated in the subserous or visceral layers of the body or in its equivalent within the neck. Examples are renal fascia and pre-tracheal fascia. More descriptive adjectives to apply to these truly deep fasciae are subserous or visceral.

A direct contradiction is found between the accepted meaning of the terms endo-thoracic and endo-abdominal fascia on the one hand, and endo-pelvic on the other. The terms endo-thoracic and endo-abdominal are usually applied to those muscular fasciae covering the internal muscular surface of the musculo-skeletal part of the thoracic or abdominal body wall. Thus endothoracic fascia includes fascia of the transversus thoracis muscle and endo-abdominal, includes psoas major fascia. These usages are wrong because the prefix "endo" means "inside of." These muscular fasciae are not inside of the musculo-skeletal layer of the body wall but are a part of it. On the other hand the term 'endo-pelvic' is customarily applied to fasciae related to urinary bladder and other viscera inside the pelvis. This usage is justified.

The soft skeleton of the body has functional equivalents to the joints of the hard skeleton. There are the serous sacks as, for example, the pleural sacks. There are the meningeal membranes with their spaces. There are mucous bursae such as, for example, those which surround certain long tendons. A great deal of es-

sentential movement of viscera would be frozen if these "soft joints" were obliterated. In classifying gross connective tissue structures we were surprised to find that a widely distributed series of connective layers that permit organs or other formations to glide on one another have no name and only faint recognition in the writings of normal anatomy.

There is such a layer between the subscapular and serratus anterior muscle where it facilitates movements of the shoulder. One is also found between the eyeball and its sheath. We term such a layer a "shearing layer" because engineers name the forces in a plant where two surfaces rub on each other "shearing" forces. These layers are made up of very loose collagenous elastic connective tissue, looser than areolar tissue. Dr. Lee at Johns Hopkins examined one histologically and found it had more elastic fibres than has areolar tissue. This type of connective tissue seems to be unrecognized in the microscopical texts.

Surgeons have long been interested in shearing layers when pathological fluids enter them and destroy their connective tissues to transform them into spaces. They call them spaces. They know that pathological processes can spread very rapidly at the expense of the delicate fibrous structure of such layers. One need only to use as an example infections in the retro-visceral shearing layer of the neck, a part of which is termed in surgery the retro-pharyngeal "space."

A second large group of gross extra-organic connective tissue structures which, apparently, have not been previously collected together and given a common name are those condensations of fibrous connective tissue which attach organs to the musculo-skeletal layers of the body, somewhat as a stem attaches an apple to a tree. The majority of these hold organs to bones. An example of these structures is the broad ligament of the uterus. Another is the connective tissue plate of the mesentery of the jejunum-ileum, and yet another, the pubo-vesico-prostatic ligament.

One might at first think that the outstanding function of these condensations is to support the weight of the organ against the pull of gravity. We believe, however, that this is only a minor and inconstant function. Let us consider for example the broad ligament. The weight of the resting uterus may be borne, in part, occasionally,

by a broad ligament as, for example, when a woman falls on one side. Most of the time, however, the weight of the uterus whether it be in the resting or the active condition is either communicated directly to the body wall or indirectly by way of organs which at the moment lie below it.

What is then the chief function of the broad ligament? It is to limit functional movements so that they will not go so far as to cause trouble. Thus in the resting uterus harmful versions are partially controlled by the broad ligament. Also the ligament helps to prevent kinking of the uterine tube.

These connective tissue formations holding organs to the musculo-skeletal layer of the body have most frequently been termed ligaments. Other terms have also been applied. For example, some clinicians in the case of the rectum speak of rectal "stalks." The scope of the term ligament has been extended so that it no longer has a well defined meaning. It is, for example, applied to certain parts of mesenteries in the abdomen. The clearly defined group of structures to which it might well be limited is those condensations of connective tissue uniting elements of the skeleton. We can not speak of the connective tissue structures between organs and the musculo-skeletal layer as supporting tracts for the reason already given. We have suggested for all of this great series the rather colorless but more accurate term, retaining tracts.

We wish to express appreciation for the stimulating discussions and constructive suggestions of our colleague, Professor Louis Plzak. This is a subject where it is especially profitable for anatomists and surgeons to confer.

* * * * *

We seem almost forced to accept the dreadful hypothesis that in the very structure and substance of all human constructive social efforts there is embodied a principle of death—that the intellect can provide no permanent defense against a vigorous barbarianism—that the fineness of moral fibre must in the long run succumb to the primitive and coarse.

—Wilfred Trotter

* * * * *

It has been wisely pointed out that a man's age can be measured by the degree of pain he feels as he comes in contact with a new idea.

MANAGEMENT OF MINIMAL TUBERCULOSIS*

Julius B. Novak, M.D., F.C.C.P.

Associate Professor of Medicine

The Chicago Medical School

Medical Director of the Tuberculosis Institute of Chicago and Cook County

THE most striking phenomenon in tuberculosis control is the constant change of our attitude toward, and modes of, control. Although the disease itself does not change, our knowledge of the behavior of this disease is augmented as the years go on. Methods of control which were held in highest esteem are now obsolete in our present-day armament. The reason for this is quite evident, when we consider that we are now finding a new type of disease; that is, minimal tuberculosis, which really is a type of disease in itself.

In the not-so-far past, say about ten years ago, we were discovering tuberculosis in the following percentage groups: About 80 per cent of all cases discovered were in the far-advanced, 16 per cent in the moderately-advanced, and 4 per cent in the minimal stage. At the present time under tuberculin surveys, mass x-ray, and intensive contact control, we have the following percentages: 62 per cent in the minimal stage, 33 per cent moderately-advanced, and 7 per cent far-advanced. This gives us a tremendous increase in the minimal cases and has brought to us an immense problem; that is, how to treat these cases. There was a time, before we really had these cases available, when it was felt that the outlook for patients with minimal tuberculosis, as contrasted with the outlook for patients with advanced tuberculosis, appeared so favorable that it seemed almost sufficient to make an early diagnosis to insure satisfactory results.

Many of the reports of excellent prognosis in minimal tuberculosis have come from sanatoria where the outlook upon minimal tuberculosis is not the same as that in the clinics at the time of early diagnosis. In the Henry Phipps Clinic, Philadelphia, Pa., even though the most modern attitude towards seriousness of minimal tuberculosis is held, the results are astonishingly poor

—almost half-developed progressive disease.

How are we to avoid these rather bad results after working so hard to discover these early cases? The answer, I believe, lies in a comprehensive follow-up of the patient once a diagnosis is made.

In most diseases the prognosis of a diagnosed case can usually be made with accuracy, provided an etiological diagnosis is available. This condition does not exist in minimal tuberculosis. As you all are aware, not all cases behave in the same manner. Some will show a spontaneous clearing under little or no treatment; some will remain static; some will be slowly proliferative; some will be quickly exudative; and some will extend in a matter of a few days to moderately or even far-advanced cases.

When a diagnosis of minimal tuberculosis is made, it is not enough to know that it is caused by the tubercle bacillus or that the lesion is quite small; but to have a working knowledge of the probable prognosis of each case is an achievement to be desired. This is not simple nor can it be accomplished with one weapon. Rather a combination of all sources of information should be used. Every case of minimal tuberculosis is an individual problem and must be handled as such. Our aim is to determine as closely as possible whether the case is retrogressive, static, or progressive. This, I believe, can be accomplished by evaluating all of the following factors in each individual case of diagnosed minimal tuberculosis.

1. *Past History:* A definite history of close and prolonged contact to an open case of tuberculosis is a positive factor in favoring a progressive disease. A negative history or an absent history of contact, while only of value in a negative way,

Reprinted from *Diseases of the Chest*, Vol. XI, No. 5, September-October, 1945.

*Presented before the Tenth Annual Meeting of the American College of Chest Physicians, Chicago, Illinois, June 10, 1944.

would bear upon the prognosis. A previous history of pleural effusion on a tuberculosis basis would definitely indicate progressive disease.

2. Predisposing Factors: An individual who is in the "teen-age" group is certainly much more inclined to progressive disease than one who is much older. Sex is a factor only in that younger females develop progressive disease faster than the males of the same age-group. Difference in race is an important factor. The colored, Mexican, and Indian races usually have more progressive lesions than the white race. People engaged in hard manual labor are much more apt to develop a progressive lesion than those who are occupied in the so-called white-collar positions. The economic status deserves consideration. Those with a high economic status are much more liable to remain static than those who have a very low economic status. Co-existing diseases are a considerable factor. Syphilis, diabetes, and long-standing non-specific disease would produce a progressive disease.

3. Present Complaint: Patients who have symptoms such as cough, loss of weight, slight temperature, night sweats, loss of energy for quite a long while, and only a minimal lesion on x-ray have a very mild progressive lesion. Asymptomatic patients give no clue to the character of their lesion.

4. Physical Findings: The absence of physical findings gives no indication as to the nature of the lesion. However, should there be present definite physical findings such as rales or altered breath sounds, then we can think of a progressive lesion.

5. X-Ray: The importance of x-ray examination does not cease when the diagnosis of tuberculosis is made. It now takes on a new role, that of recording changes in the existing foci or the presence of new lesion. Serial x-rays taken at six-week intervals will indicate change and hence the presence or absence of progressive lesions. It is a foolhardy man who will give a prognosis on the examination of a single x-ray film.

6. Sputum Examination: The presence of positive sputum indicates a progressive or active lesion. This can be obtained from direct smears or gastric washings.

A complete evaluation of the above factors

will usually lead us to following three catagories: (a) Active, progressive, unstable disease; (b) Lesions of doubtful significance; that is, we cannot determine whether or not activity is present; (c) Lesions where general score would indicate or suggest complete static or healed state.

The management of each group is definitely different. Lesions that are determined to be progressive demand active treatment. This means the instituting of collapse therapy and complete bed rest. This is best accomplished in a hospital or a sanatorium. Conditions may be present where hospital or sanatorium is not available. In such a case complete bed rest with collapse therapy at home is indicated. The treatment of lesions of doubtful degree of progression demands a realization that the lesion might become activated by home conditions. It is important that the patient is given the benefit of the doubt and have a period of rest with observation. Complete bed rest with serial x-rays will indicate whether there has been any progression. If there is no change in the x-ray appearance, it is now safe to consider these lesions as static.

All static lesions should be examined at two-month intervals. This type of treatment would be considered as observation with modified rest. The patient must be considered to be a potential case at all times and should have regular x-ray examinations at three-month intervals as long as two to three years.

SUMMARY

There is no such thing as a routine treatment for minimal tuberculosis. It is equally absurd to say either that every case should receive pneumothorax or that collapse should never be used until the disease becomes moderately or far-advanced. Every case must be individualized, and this can be done only by a proper follow-up to determine just what is happening in each case. As yet we have no test which will tell us just what the future potentialities of the case are. Only the tedious, difficult, close follow-up is now available; and using this method will give us the best results obtainable.

* * * *

*A man without GONADS is void;
His animal can't be cloyed;
His lack of potentia
May lead to dementia,
According to Adler and Freud.*

THE CIGARETTE AND MOTHERHOOD

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IS smoking injurious to the mother and her baby in the womb?" That is a common question asked by the public of scientifically trained people. It cannot be answered from casual observation or wishful thinking. It can and must be answered on basis of data gathered from experimental work.

In this paper a report shall be given of an experiment performed by the writer and his associates, Drs. Justin V. Schwindt and Anne R. Patras on the albino rat (1). Also a brief summary of the work and results obtained by other students of the smoking problem, particularly on the human being.

Results from Experiments with Rats

In the first part of the experiments, female white rats were daily subjected to the fumes of tobacco smoke during the entire period of pregnancy and lactation. The amount of smoke that the rats were to inhale was figured to be equivalent to that of human beings consuming one package of cigarettes per day.

In the second part of the experiment pure nicotine diluted with distilled water was injected below the skin or into the body cavity. The injection was continued from conception to the time of weaning the young. The nicotine content was approximately the same in both experiments. The second method was a sort of check on the efficiency of the first method. The results of both methods were similar. The inhalation method proved to be less severe on both the mothers and the young than the injection procedure.

The experimental rats were compared to normal rats, or controls, in each experiment. Most of the controls were litter-mates, that is, born at the same time and of the same mother as the treated animals.

Our first attempt was to determine the effect of tobacco on the weight of the young. In order to avoid the objection raised against other investigators, that their results rested on too few

animals, we used for this purpose 592 young from treated mothers and 113 controls. The results of this experiment showed that a very large proportion of the young from treated mothers fell much below the weight level of the controls. The injected ones were lower than the smoked rats.

The weight record of the treated mothers called our attention to another effect of tobacco. The rapid addition of weight in a number of mothers showed that the embryos were developing in their uteri. However, culmination of the weight increase was reached a week or several days before birth was anticipated. This was followed by loss of weight, until often less than the former weight of the mother was reached. It was evident that the young died while in utero and were gradually absorbed. Since these effects were not noted in the control rats, the conclusion is inevitable that death was caused by nicotine. Three of the mothers gave birth to dead, partly resorbed and mummified young; two of these mothers died a few days later.

The neglect of the young by their mothers, was one of the most common effects observed in these experiments. The mothers seem to have lost their maternal instincts; they failed to build an appropriate nest for the young; the young were often found scattered all over the floor of the cage, cold and unfed, but she paying no attention to them. Many of the young were devoured by her even though she was properly fed on a meat diet. The young at birth appeared normal so far as external appearance goes, except that many were somewhat smaller in size and weaker in body. Such were the results. Some questions are admissible as to interpretation. The mother's detestation of the poisoned young may have been keener than would be that of the human mother. There is a tendency in nature to eliminate the unfit. Of the 104 mothers used for this part of the experiment, 45.8% lost one or more of their young before they reached the weaning time; 23.4% lost all of their young before they were weaned. An appreciable number

of the young that survived, died before they reached maturity. The death rate of the mature rats was greater than those of untreated rats.

In another experiment, it was desired to know to what extent the growing egg cells in the ovary of the mother can be poisoned by tobacco smoke. The females were subjected to daily inhalation of tobacco smoke for three weeks each. Then the treatment was stopped and the females allowed to become pregnant. Two litters were obtained from each female. The results showed that 33.3% of mothers lost one or more of their young before weaning; 25% of the young were underweight.

Such are the major results of our experiments up to the time of writing. Several other symptoms such as prolongation of pregnancy, still-births, sterility and emaciation of the mother, have been noted, but further study is required before these can be evaluated. In all of the experiments considerable variation has been noted. Some of the young from treated mothers weighed as much as the heaviest of the controls, and some of the treated mothers seemed to give as good care to their young as to untreated mothers. These, however, must be regarded as exceptions. As to whether this is due to a quick elimination of the poison before injury can take place or whether their injury is of such nature that it escapes observation, cannot be answered at the present time. The conclusion seems inescapable that at least for a large part of our experimental white rats, tobacco proved to be injurious to both mothers and offspring.

It is often assumed that whatever is true in experimental animals is equally true of human beings. This is far from being true. The results here obtained can be applied to man only insofar as it can be shown that the latter reacts to tobacco in a similar fashion as do white rats. A brief summary of the publications on this subject is now in order.

Results Gathered from a Review of Literature

The conclusions reached by writers as to the effect of tobacco on the human body are extremely variable; probably more variable than on any other biological problem. On one end of the line one finds claims that tobacco is responsible for practically all the ailments of the human race, while at the other end, extreme assertions

are found that tobacco is not only not injurious but that it is beneficial, "the best friend of the human race!"

The reason for this state of affairs, as well known to every intelligent person, are many. The most important one, it seems to the writer, is the fact that human beings cannot be handled like rats and guinea pigs. Experiments with proper controls are difficult to carry out. The studies that have given most reliable results have come from three sources: tobacco workers, smoking mothers, and a study of college students.

A Study of Tobacco Workers

For many years it has been known that nicotine poisoning often occurred among tobacco workers, particularly in places where a long work day and unsanitary conditions prevailed. Closer study revealed that nicotine is rapidly absorbed by mucous membranes, the lungs, and the skin. As a consequence, impairment of respiratory function is claimed to be more common among tobacco workers and their children than in people not so occupied. The day after day poisoning of ovaries and womb is claimed by some to bring about the following ailments: painful menstruations, difficulties in childbirth, more abortions, greater infant death rate, fewer pregnancies and reduced sexual desire (2). Further signs of poisoning of the skin and the blood system may be identified with anemia, —the washed-out leathery skin condition and early old age. Other investigators have found the above conditions exaggerated or even altogether false. This has tended to spur on re-investigation of the problem in practically all parts of the tobacco consuming world. The consensus of opinion favors the former claim rather more than the latter.

A Study of Smoking Mothers

The literature on this phase of the study is very extensive. It consists mostly of reports of individual smokers, although a few group studies are available. The results of these have greater objective value because of more adequate controls. The amount of nicotine obtained depends on the manner in which the cigarette is consumed; inhaling gives 8 to 9 times as much as non-inhaling; fast smoking liberates twice as much nicotine as leisurely smoking (3). Nicotine is one of the drugs that give a brief stimulation followed by depression. The excretion

depends on the vigor of the individual smoker; it appears in urine one and a half hours after smoking. It has been shown experimentally that nicotine passes the wall of the chorionic villus with no apparent interference. Its presence in the embryonic system can be readily demonstrated because it increases the fetal heart rate 8 to 12 minutes after the pregnant mother lights a cigarette. Nicotine is found in the mother's milk in one to two hours after a smoke. Cramps, restlessness, vomiting and emaciation are the more common symptoms of a baby poisoned by nicotine containing milk (4). It has been shown in animal studies that nicotine interferes with the development of the mammary gland. The heart rate of the mother increases 8 to 40 beats from the consummation of 2 to 10 cigarettes. It is claimed that day after day poisoning raises blood pressure, causes irregular heart, nervousness and sleeplessness. The poisoning of the uterus and ovary followed by complications in menses, child-birth and fertility are also reputed in these studies (5). Needless to say, that the above claims are not corroborated by all investigators, although the disparity is less severe than in the former study. We are told moderate smoking to the extent of from two to five cigarettes per day, per contra, need not be injurious to either mother or child.

A Study of College Students

This is by far the best controlled method of study in the human family. Unfortunately, the field covered is not extensive and it is concerned mostly with men. Statistical studies at many universities have tended to show that non-smokers stand higher in scholarship. Objections raised to this conclusion claim that non-smoking is not the cause of higher scholarship but that quite the contrary, the higher scholarship is the cause of non-smoking (6). Non-smokers are better athletes; they possess greater skill, endurance and accuracy than smokers do. This claim has been strengthened by the studies of smokers and non-smokers among Morse code workers (7). These showed that smokers fatigue and become less accurate sooner than non-smokers. That nicotine interferes with muscular activity and co-ordination has been proven in various precision exercises such as dart throwing; the efficiency of the same individual can be shown to decrease after the consuming of a cigarette (8). It is interesting to note in this connection that

only non-smokers are acceptable in many occupations.

Conclusion

After allowances are made for whatever over-emphasis may have occurred in the three methods of study, it is important to note that all of them agree that tobacco is injurious to the health of man, woman and child. This conclusion is further strengthened by similar findings in animal experiments of our own and of other investigators.

It may be true that two to five cigarettes per day may not be injurious to a woman whose constitution is strong enough to throw off the poison quickly, but can this be done by every woman? Furthermore, how many persons can control the tobacco habit? Many a woman has started smoking one to two cigarettes per day but at onset of pregnancy has smoked twenty to thirty per day! There is no mechanism known to science that will shield the baby, either in the womb or at the mother's breast from the flood of nicotine. The results of such exposures to the poisoning of the young cells of the embryo may be much more severe than we have any means to measure or to comprehend at the present time.

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BURNS OF WORLD WAR II

Louis J. Polskin, Ph.D.

FROM the point of view of grave, physical consequence, broken morale, and disastrous effects on the mental well-being, the burn casualty constitutes a serious problem in World War II. Final statistics of burn casualties are still incomplete and reports vary markedly depending whether the combat occurred on land, on sea, or in the air. Burns have been more common in this war than in World War I (Capt. Hayden, '44). It is estimated that burns comprised as little as 2% of the present war wounds (Major Gen. Kirk, '44) to as much as 60% of the wounded in certain incidents; as was seen in the attack on Pearl Harbor, December 7, 1941. (Capt. Hayden, '44; Capt. Kern et al, '43; Capt. Hook, '42).

Major General Ogilvie, chief consulting surgeon of the British Arms of the Middle West, reported that in the hospitals of this area for the year, March, 1942 to March, 1943, there were 6293 patients with burns, of which 141 died, giving a mortality of 2.2%. (Brig. Gen. Rankin et al, '44).

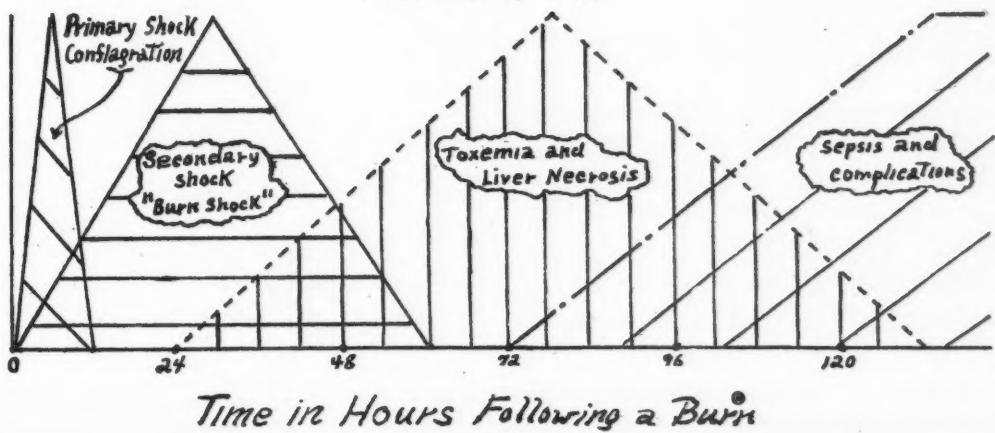
Although in sea warfare the ratio of burns to other casualties is generally higher than in land warfare (Lt. Comdr. Berkow, '44), the low mortality figure cited for burn cases is in close agreement with the estimated mortality rate of less than 3% for all participants in War II. (Col. Borden, '44). The three reasons for low mortality figures in this war are cited by Brig. Gen. Rankin et al ('44) in order:

- (1) blood plasma
- (2) adequate surgery through adequate medical organization to insure that men get back to field hospitals
- (3) the "sulfa drugs"

The naval medical records (Capt. R. Hadyen, '43) reveal that the use of sulfonamides and blood plasma has reduced the death rate of American troops wounded in the Solomon Islands to less than 1% as against 7% in World War I of all American soldiers wounded in the field. Actually

Chart 1.

Showing Overlapping Occurrence of the Main Causes of Burn Death (Harkins, '43)



burn patients do not die of their burns but rather as a result of systemic changes which burns induce (Chart 1) notably, shock, toxemia, and sepsis (Harkins, '43; Capt. Kern et al, '43; Lt. Walton, '44).

According to Harkins ('43) "various estimates have put the percentage of deaths that are due to shock at from 60 to 75% of the total number deaths in cases of burns.—Atkins in treating burned patients evacuated from Dunkerque states that secondary shock is the most serious factor in burns and is responsible for 60% of the deaths occurring in this condition."

Lt. Col. Walton ('44) divides patients suffering from burns into two broad classes, "the quick and the dead. The quick survive primarily because of the presence of enough intact skin compatible with life." It is noteworthy that in any wartime burn of more than 70% of the total body surface, as from second degree burns (blister formation) or especially third degree (total skin thickness destruction), the case is beyond hope of cure, with irreparable shock changes**, and in such instances treatment should be limited to relief of suffering. Capt. Hamilton and Lt. Barnett, ('43) cite mortality figures of Lt. Col. W. C. Wilson for the British 8th Army (Middle East Forces) to bear this out:

<i>Extent of Burn</i>	<i>Approximate % Mortality %</i>	
Small	to 10	0
Moderate	15-20	24
Moderate to extensive	20-25	60
Extensive	25-50	91
Very extensive	over 50	100

***Mnemonic Summary of Burn Shock* (Morani, '44)

S—Seepage through the capillaries following capillary dilatation causing loss of plasma.

H—Hemoconcentration with decreased blood volume and blood flow and increase in hemoglobin and hematocrit.

O—Oxygen want or anoxemia of the tissues.

C—Cardiac output decreased because of loss of plasma by seepage into the tissues.

K—Potassium salt increase with decrease of sodium, chloride, and protein.

(Hemoconcentration is the most important di-

agnostic and prognostic sign of shock in uncomplicated burns).

Extent of Burns

There are many possibilities of conflagration which are met under war conditions, viz—"flash" burns, phosphorus burns, vesicant war gases, and sunburn. The sailor, flier, and tank soldier faces fires in ships, planes, and tanks, exposed circuits, friction, (especially when sliding down ropes) live steam, and burning oil on the sea. Capt. Hook reported that most of the burns among navy personnel came from turret accidents, explosions from torpedoes, and bombs below decks, and explosions about motors. (Lam-Harkins, '42).

Defining a 1st degree burn as an erythema, a 2nd degree burn as having vesication, a 3rd degree burn as destruction of the epidermis, and a 4th degree burn as involving subcutaneous fat and deeper structures, steam burns manifest themselves as 2nd, 3rd, and 4th degree and are worse on the covered parts where the greatest thickness of clothing holds the heat longer. (Capt. Kern et al, '43). Electrical burns are almost always 4th degree. Burns from ignited gasoline or oil are deepest, often 4th degree, the face revealing only a 1st or 2nd degree burn. Gasoline or fuel oil burns rank high in incidence. Of 360 burn patients on ship and shore Capt. Kern et al, ('44) reported 254 flash burns and 57 gasoline burns, while Major Johnson ('44) cited 108 burns



in New Guinea, over 90% of which were the result of gasoline fires or explosions.

The British Air Ministry in Pamphlet No. 168 ('44) note that burns among R. A. F. aviators have a characteristic distribution involving chiefly the face (Figure 1) and encircling the hands, with or without other significant areas as legs and thighs. These "cockpit fires" cause deep burns from the intense heat of burning fuel and although may not be a threat to life, may prove functionally severe. (Maj. Rank, '42).

The record of areas burnt in 300 men at Tobruk showed that seldom only one limb was involved. (Lt. Col. Logie, '43). The regions varied "from the surface of both upper extremities, with or without the face to that of all four limbs of body, back and front."

It has been found that practically all war burns reaching Walter Reed Hospital involved the extensor surfaces of the hands, and in the multiple burns the hand lesion was almost more severe. (Capt. Hamilton and Lt. Barnett, '43). Burns of the lids are as common as face burns but fortunately the wink reflex serves to protect the cornea and conjunctiva from serious involvement. (Capt. Kern et al, '43). Even in the exceptional victim, unconscious, with eyes open at the time of the flash, "the lesion of the cornea is likely to be below the level of the pupil."

Accidents vs. Battle Burns

The number of burns that have resulted from accidents and carelessness under war conditions is appalling. In reviewing the causes of 300 burns managed in a clearing station prior to the fall of Tobruk in 1942, Lt. Col. Logie ('43) found that most of the burns were due to the misuse of petrol viz. "sand fires, debugging dugouts, lighting matches while clothes of dressings on hands were petrol soaked." In an overseas army general hospital which received casualties from the Sicilian invasion, Major Rawles and Capt. Massie ('44) found that a majority of the soldiers were burned as a result of negligence, 55% (of the 78 cases) being "burned by gasoline in a manner that was probably preventable or unnecessary." In the report on the North African theater, of 1942 Col. Wilson showed that the ratio of accidental burns to those sustained in combat was 2.3 to 1. (Capt. Hamilton and Lt. Barnett, '43). The accidental burns were frequently sustained

from desert stoves, namely a pot of sand soaked with gasoline. Major General Ogilvie, cited above, reported that of the 6293 burn patients in the hospitals of the Middle East for the year 1942-43 "80% were accidental, almost entirely due to carelessness in cooking with petrol stoves and only 20% with real battle casualties." With his standard that a *serious* burn is 10% of the body surface (Figure 2) he concludes 40% of the battle casualty burns are serious compared to 24% of the accidental burns, and the death rate of the battle casualty burn is 6.6 as against 1.1 of the accidental burn, not overlooking that the patient with a battle burn may die from other things as wounds, blasts, and injuries. For example, pressure from bombs produces pulmonary injury, if a victim should be struck with a force of one hundred pounds per square inch. Furthermore, carbon monoxide poisoning is always to be considered in the close proximity of a bursting bomb. (Col. Borden, 44).

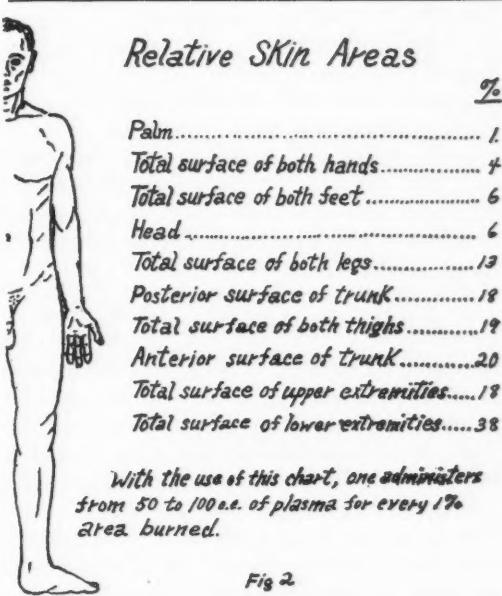


Fig 2

"Flash" Burns

The flash burn was described in World War I, but was soon forgotten until its striking reappearance in War II, (Capt. Roddis, '44) being one of the commonest burns in battle. (Capt. Hamilton and Lt. Barnett, '43). It is caused by the flare and explosion of powder, exploding projec-

tiles, bombs, torpedoes, particularly in enclosed spaces. In enclosed places, as on a ship, it may shoot down a passageway burning men distant from the source. (Capt. Roddis, '44). On shipboard or on land, Col. Borden, ('44) points out, this pressure wave of fire is accompanied with such force that it often knocks men off their feet. Moreover, the back of the scalp of sailors subjected to such burns "is entirely bald where hair and scalp has come in contact with the deck. The metal deck is so heated by the blast of an exploding bomb or torpedo that it will burn the unprotected parts of the body upon contact."

The flash burn is unique in that it is almost never 4th degree (Capt. Kern et al, '43) and that only exposed parts of the body are involved, viz. the dorsum of the hand as it is thrust up to protect the face. (Capt. Hamilton and Lt. Barnett, '43). Thus in the air raid on Pearl Harbor many men rushed to their posts in various states of undress and the exposed skin was easily seared by flash burns. Of the 254 burn patients (about 60% of the total wounded) practically all were flesh burns, mostly 2nd degree, from exploding bombs or torpedoes. This number was admitted to the hospital within three hours and 65 died from burn complications according to Capt. Hook. (Lam and Harkins, '42; Capt. Hayden, '43). Men fully dressed were burned only about the face and hands, while those wearing only trunks were burned everywhere (70 to 80%) except over the hips.

A projectile, on striking a tank generates a vast amount of heat and force, which may chip the metal within the tank, and ignite inflammable material, thus injuring or burning the members of the tank crew. (Col. Borden, '44). Furthermore, the latter pointed out that in the older tank model, which preceded the modern welded type, a bomb smashing against it, although not penetrating the walls, nevertheless transmitted such force that "boltheads were broken loose inside the tank to become secondary projectiles."

Phosphorus Burns

This burn, produced by incendiary bombs and tracer bullets, is a new type of burn of War II. (Col. Borden, '44). The wound is very painful, without blistering, has a chronic healing period, and tends to become septic. Phosphorus is lipid soluble and spreads rapidly and destructively into the deeper tissues. (Obermer, '43). The

burn gives a grayish white reaction, according to Col. Borden, which many times produces vapor arising from the wound! The latter may prove a desirable point in locating the embedded Phosphorus, or if on removing the wounded to a darkened room, the Phosphorus becomes fluorescent. In view of the unique characteristics of this type of burn, it is obvious why immediate treatment is essential. By rubbing off the burnt epidermis with a freshly mixed solution of 20% copper sulfate and 0.8% sodium bicarbonate in about equal parts, the phosphorus becomes visible as "dead white with a faint bluish tinge." (Obermer, '43). The latter cautions that this solution cannot be kept mixed and must be freshly prepared since insoluble cupric carbonate will form, destroying the effectiveness of the copper ion to combine with the phosphorus to form the phosphatide of copper. Col. Borden ('44) suggested the addition of 1% copper sulfate alone to blacken the phosphorus so that it can be seen and subsequently removed with forceps, under anesthesia.

Prevention of Burns

In the tropics, Capt. Roddis ('44) reported the prevention of flash burns by wearing "long handled" underwear and long sleeved shirts. Even tying the pants cuffs and sleeves with a string prevented the flash from darting up the extremities! He points out that a protective film, as a paint for hands and face, is yet to be perfected. Most of the face and hand burns in airmen are preventable by the wearing of helmets, goggles, and gloves. The British Air Ministry in Pamphlet No. 168, ('44) urged R.A.F. men to wear the aforementioned "not only during flight but also at take-off and landings when most accidents associated with burns occur."

In naval action Capt. Kern and his coworkers ('44) maintain many burns can be avoided by enforcing:

- (1) full clothing at battle stations
- (2) wearing antiflash, fireproofed gear
- (3) constant availability of gloves for sliding down ropes and fighting fires.

On shipboard, be it a merchant vessel or man-of-war, fire drills are a regular part of routine. Conflagrations can be prevented from spreading by closing water-tight doors, shutting the ventila-

tion system, flooding ammunition space, and lining fuel tanks and pipe lines behind armour. (Capt. Roddis, '44). The latter points out that the modern tank has been also safeguarded by reducing fire hazards through the use of heavy oil type of engine, provision for fire extinguishing equipment, and "non conductors as lining for tanks." Tank men wear helmets and gloves, like airmen, to lessen the extent of flash burns. "Men are instructed to hold their breath to prevent inhalation of flame, producing the fatal burns of larynx, trachea, and bronchi."

The "Burn Committees" in England, Canada, and U. S. emphasize the importance of a "burn team" to carry out the best definitive treatment for burn casualties. (Col. Borden, '44; Whipple, '43). Such a team would consist of a "general surgeon interested in problems of infection and wound healings, a physician or technician thoroughly trained in problems of fluid, protein, electrolyte balance, a general plastic surgeon with experience in skin grafting** large granulating areas, a group of trained nurses, and orderlies able to stand the stress of caring for severely burned patients." The achievements of such a well organized team should not end with burn casualty during war time, but has excellent possibilities in civilian hospitals during peacetime.

**It is interesting to point out that application of skin grafts reached 60% among the burn casualties in a survey made by Lt. Col. J. B. Brown ('44), which markedly surpasses any similar effort in World War I. In fact, "the Section on Plastic Surgery in the Medical Department Report of the last war does not mention skin grafts except in one short reference. Neither does it mention burns!"

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* * * * *

"Diseases of the heart and arteries killed more than 536,000 persons in 1940, but only \$93,835.00 was spent that year on research on these diseases. By contrast, \$2.18 research money was spent for each of the 164,906 cancer deaths, \$4.00 for each death from infectious disease, other than infantile paralysis; and \$525.00 for each of the 1,026 infantile paralysis deaths or \$100.00 for each case dead or seriously crippled."

—Simms, Rhode Island M.J.

* * * * *

Old or young, we are all on our last cruise.—R. L. Stevenson.

OUR NEW TRUSTEES

JUDGE LOUIS E. LEVINTHAL

Judge Louis E. Levinthal, one of Philadelphia's most illustrious citizens, has been recently elected to the Board of Trustees of The Chicago Medical School. Judge Levinthal was born on April 5, 1892, in Philadelphia, Pa., the son of Rabbi and Mrs. B. L. Levinthal. He received his elementary and High School education in Philadelphia, where he attended Central High School. Judge Levinthal received his B.A., Cum Laude, from the University of Pennsylvania in 1914; LL.B., Cum Laude, Law School of the University of Pennsylvania in 1916; LL.M. 1918, also from the Law School of the University of Pennsylvania. He was editor of the University of Pennsylvania Law Review, Member of Phi Beta Kappa and Order of Coif (honorary legal society), and was awarded the Gowen Memorial Fellowship.

Judge Levinthal then began his career of philanthropic and public services. From 1933-1936, he was lecturer on Bankruptcy and Corporate Reorganization at the University of Pennsylvania Law School. From 1935-1937 he was Special Counsel to the Public Service Commission in connection with the reorganization proceedings of P.R. T. Since March 15, 1937, he has served as Judge of Common Pleas No. 6 of Philadelphia County. In spite of these pressing duties, he also found time to write the following: "Mayer Sulzberger P.J.", "Early History of Bankruptcy Law," and "Credo of an American Zionist."

Not only has Judge Levinthal actively participated in matters pertaining to the legal world, but he has also found time to be as actively a participant in the following social and cultural endeavors:

Former Chairman of American Palestine Appeal of Philadelphia

Former President of Associated Talmud Torahs of Philadelphia

Member of Board of Directors of Federation of Jewish Charities and Allied Jewish Appeal of Philadelphia

Member Board of Directors of Public Charities Assn. of Pennsylvania

President of Gratz College of Pennsylvania

Former President of Zionist Organization of America

Vice-Chairman of National Council of United Palestine Appeal

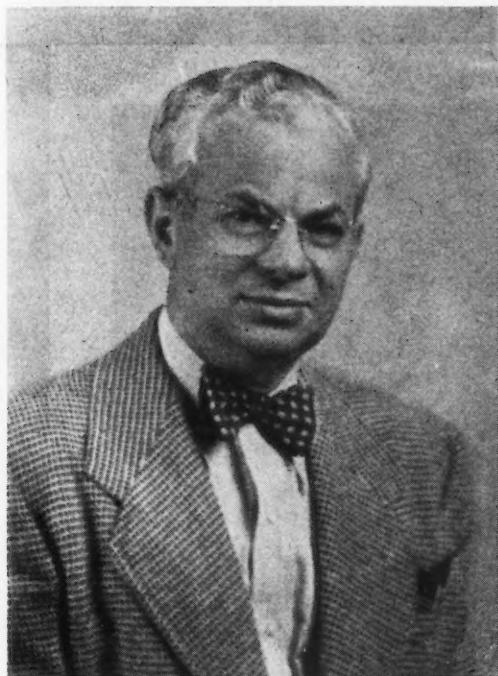
Member of National Executive Committee of the United Jewish Appeal

Judge Levinthal has one daughter, Sylvia, living in Chicago, who is married to Dr. Herbert I. Bernstein.

It is with great pleasure, therefore, that we welcome Judge Levinthal to the Board of Trustees of the Chicago Medical School.



Judge Louis E. Levinthal



Mr. Albert H. Lieberman

ALBERT H. LIEBERMAN

Albert H. Lieberman has been a prominent and active figure in Philadelphia social life for many years. Mr. Lieberman has not limited his interests to the city of Philadelphia, however, as evidenced by his membership in the following national organizations:

President, National Council, Joint Distribution Committee
Member, Executive Committee, Joint Distribution Committee
Member, Advisory Committee, American Jewish Committee
Assistant Treasurer, American Jewish Committee
Vice-President, Hebrew Immigrant Aid Society
Member of the Board, National Refugee Service
Member of the Board, Jewish Telegraphic Agency
Member of the Board, National Jewish Hospital at Denver

(Continued on page 38)

MARK SUGARMAN

Mark Sugarman, of South Coatesville, Pennsylvania, a leading investor and developer of communities in the eastern part of the United States, has recently been elected to the Board of Trustees of the Chicago Medical School. Mr. Sugarman was born in New York City. He attended Public and High School in New York City, and received his college education at the St. Lawrence University, where he also received his L.L.B.

Early in his career he was engaged as an Executive Officer of large building developments in New York City. Later, he successfully entered business for himself, and now his holdings spread over the states of Pennsylvania and Massachusetts.

Parallel with his business success, Mr. Sugarman has also found time to participate in many community and civic affairs. He is president of the Eastern Pennsylvania Region of the United Palestine Appeal; a member of the National Ex-

(Continued on page 38)



Mr. Mark Sugarman



Captain Walter Eugene Block (1903-1944)

Alumni News

Capt. Walter Eugene Block (1903-1944)

Many of the first 238 American Rangers landing at Pont du Hoe, on the east coast of France, died as they reached the top of the cliffs and fell to the beach below, where the doctor, Capt. Walter E. Block, of Chicago, was already at work. Dr. Block, with the aid of his assistants, worked for 66 hours under German gunfire, and handled over 50 American casualties. On December 8, 1944, Dr. Block was killed in action in Germany during his fourth major battle.

The death of Capt. Walter E. Block was a very great shock to the Chicago Medical School. Dr. Block entered the Army Medical Corps in July 1942, leaving behind his wife Alice and their three children. In November 1943 he went overseas and was stationed in England. During his stay in England, Dr. Block became discontented and restless with the "tea drinking" and decided to offer his services to the American Rangers, one of the most dangerous assignments in the armed forces. It was in the service of the Rangers that Dr. Block distinguished himself as a doctor, a soldier and a gentleman, and won for himself the admiration of all who knew him. He was awarded the Silver Star, the Presidential Unit Citation, the Purple Heart, the Bronze Star with Oak Leaf Cluster, and the Distinguished Service Cross.

Dr. Block was a graduate of the Class of 1929, and served his internship at the Baptist Hospital, Houston, Texas. He was a member of the staff of the St. Mary of Nazareth Hospital.

The whole student body and faculty mourn the loss of Dr. Walter E. Block and extend their deepest sympathy to his wife Alice, and their three children.

1926

The Quarterly announces with great sadness the death of Dr. Maurice D. Chernoff. Dr. Chernoff died of a cerebral hemorrhage in the Garfield Park Hospital. He was 43 years of age.

We are very happy to learn that Dr. Herbert B. Erickson, who was recently discharged from the Medical Corps, has opened offices at 7439 Cottage Grove Avenue.

THE QUARTERLY

1930

A recent visitor to the School was Capt. Jacob C. Augenlicht. Capt. Augenlicht was recently discharged, and prior to resuming his practice, is taking a well-deserved rest.

We are extremely happy to receive a communication from Capt. W. Y. Tse, who reports that he has just returned from overseas and that he will go back to his private practice as soon as he is discharged. Dr. Tse is one of those alumni with whom we had lost contact, and so we're doubly glad to hear from him.

1932

Capt. Felix R. Baylin recently wrote us that his address is: Chief of Dispensaries, Medical Staging Service, Camp Stoneman, California; and that he would enjoy hearing from his former schoolmates. Capt. Baylin also wrote that he is the proud father of a 5-month-old baby girl; a future Hollywood star, no doubt, Captain Baylin?

Major Sidney R. Bazell has left the Fletcher General Hospital, Cambridge, Ohio, and is now on terminal leave. If you are ever in our neighborhood, Major, we hope you, as well as all our other alumni, drop in to say hello.

1933

A recent visitor to the School was Dr. Allen R. Morrison (C.M.S. '33), who had served as a Lieut. Colonel, M.C., A.U.S. He has resumed his medical practice at 1422 S. 5th Ave., Maywood, Illinois.

Capt. Harry Tyllas, member of the 101st Airborne Division (the original "Battling Bastards of Bostonia") has returned to the United States, after having been captured during "The Battle of the Bulge" and imprisoned by the Nazis for two months. He was wounded in Normandy on D-Day-plus 3, and was subsequently awarded the Purple Heart, Bronze Star, and numerous battle stars.

1934

A welcome visitor was Dr. Herbert P. Rashe, who was very recently discharged from the Medical Corps. After a vacation in Florida with his family, Dr. Rashe will resume his practice in Maywood, Illinois. While in the service, Dr. Rashe served as a Flight Surgeon with the Pathfinder Group of the 2nd Squadron.

The Quarterly was very pleased to learn from

Mrs. C. H. Resnick that her husband, Capt. Carl H. Resnick, has been decorated with the Bronze Star for meritorious service in Italy, France and Germany, from April 20, 1944 to March 3, 1945. Capt. Resnick, who is the father of two daughters, Roslyn, 6, and Lois, 4, entered the Army Medical Corps, October 12, 1942.

Dr. John T. Porter was recently advanced to the rank of Colonel in the Army Medical Corps. Our heartiest congratulations to Colonel Porter, a good soldier and an even better doctor.

A recent visitor was Major Thomas H. Culhane, who has resumed his practice in Rockwood, Illinois. Since his discharge from the service, Dr. Culhane has taken a post-graduate course at Harvard University.

1935

Capt. George Karay kept us fascinated by relating his experiences in the Pacific theater of operations from which he has recently returned.

1936

Dr. Joseph Fireman has reopened his office at 1738 Willow Rd., Northfield, Illinois.

Capt. Alex Berman was a recent welcome visitor.

1937

Major A. W. Wellstein stopped in to say "hello." He is at present awaiting his discharge papers from the Army Medical Corps.

1938

A recent visitor at School was Capt. Paul E. Armstrong, who has fully recovered from typhus which he contracted during his service in Burma. Dr. Armstrong expects to be discharged from the Army soon, after which he intends to resume his practice.

Major Hannibal P. Paolozzi has written that he has been discharged from the Army and expects to return to Chicago soon. He writes, "I am awfully glad to be back and be able to start again where I left off. All I can say is that it's great being on the winning side—and all efforts taken were certainly worth-while."

Dr. Morris Peterson was a welcome visitor at School after recently being discharged from the Medical Corps, A.U.S. Dr. Peterson has opened his offices for general practice at 4201 W. Madison Street, Chicago.

Capt. William Yacullo spent considerable time in the Dermatology Clinics during his leave, and made many valuable additions of knowledge from his Army experience.

We were very happy to hear from Capt. Bernard F. Rosenblum telling us that he has fully recovered from injuries received after a Jap air-raid on Okinawa. Dr. Rosenblum suffered a fractured skull and internal injuries. Capt. Rosenblum was awarded the Pacific Theater ribbon with two battle stars, the Philippine Liberation ribbon with two battle stars, the Assault Arrowhead and the Purple Heart. He has now resumed his practice at 1354 W. Devon.

1939

A very welcome letter was recently received from Capt. Morris Fox, who is stationed at O'Reilly General Hospital, Springfield, Missouri. Capt. Fox is commanding officer of the 18th General Hospital.

Capt. Jacob M. Epstein was a recent visitor at School. Dr. Epstein was discharged in October, having been in the service three years. He served in the European theater and says it feels mighty good to be home again.

Dr. Peter Berman was recently discharged and will soon resume practice after a brief rest.

With great pride we point to—Leon M. Hart, M.D., F.R.S. "Admission into the Royal Society is most difficult to secure and therefore . . . a most coveted honor. Fifteen new members may be received annually, and each candidate must be vouched for by six members," states the World Book Encyclopedia. The title of Fellow of the Royal Society is one of the most distinguished awards in the field of science, having its origin at the time of Charles II in the year 1662.

And, should some of you ask, "What else?"; Dr. Hart was awarded the Bronze Star, the Silver Star, and his unit received eight battle stars, the Crcix de Guerre, and two Presidential Citations. His unit was publicized as one of the five "hardest hit" at the Anzio beachhead. He also saw action in North Africa, southern France, and Alsace-Lorraine.

Back now in Chicago once again, Dr. Hart has just opened his office at 4752 Lincoln, and we of the *Quarterly* wish him the very best of luck in his practice. It's with great satisfaction that we point to this graduate of 1939. Lest we overlook an-

other accomplishment, Dr. and Mrs. Leon M. Hart will celebrate their first wedding anniversary on January 23, 1946.

1940

Capt. Charles Morris was a recent visitor at School, after serving as a Flight Surgeon in the Army Air Force Medical Corps. Dr. Morris had served in African and Italian campaigns and was stationed for eight months at the Convalescent Hospital of the Army Air Force in St. Petersburg, Florida. He has been awarded the Purple Heart and the Silver Star. After his discharge, Dr. Morris plans to enter general practice.

Word has been received from Dr. A. Estin Comarr from Los Angeles that while in Germany he was promoted from the rank of Captain to that of Major, and was appointed Division Medical Inspector.

Dr. Sol Scholnick recently visited the School after just returning from the Pacific and being discharged. Dr. Scholnick intends to open his practice in the near future.

Major Frederick Spector writes from Hall, Germany, where he is stationed with the 20th Field Hospital. He is looking forward to returning home in a few months.

Major Adio A. Freedman returned from Germany in August and is now serving as a psychiatrist at the Medical Section Separation Center at Camp Atterbury, Indiana.

Dr. Eugene Warsaw has been released from the Medical Corps and has opened his offices at 7058 Chappel Avenue, Chicago.

Two old classmates, Capt. O. J. Giovanelli ('40) and Capt. Martin Green ('40), stopped by to say "hello." The two Captains are both looking wonderful and we are awfully sorry that they missed seeing each other by three days.

1941

Capt. Charles L. Leach was a recent visitor at School, while he was on terminal leave. Capt. Leach was in the European theater of operations for 26 months, and after 38 months of military duty is contemplating post-graduate study in Internal Medicine.

The Quarterly was recently informed that Capt. Bernard F. Howland is a patient at the Percy Jones General Hospital at Battle Creek, Michigan, and is nursing a serious injury to his arm.

Our best wishes go to Capt. Howland.

Capt. M. D. Bennin has returned from England and is now stationed in Milwaukee, Wisconsin.

Capt. Arnold Block, who was awarded the Purple Heart and Presidential Unit Citation, visited the School recently. We were happy to see him.

1942

Capt. Harry M. Siegel was a recent welcome visitor at the School.

1943

"Have transferred surgeon by breeches buoy in heavy sea. Standing by." This dramatic message indicated to the troopship *Frederick Victory* that help was coming for a stricken soldier. Less than four hours later, Lieut. Eugene Brodsky was back on his own ship reporting, "Operation successful. The patient is doing well." Just another routine call for a Coast Guard surgeon, but we would rather go by car. Congratulations to you, Dr. Brodsky. Now we understand why your father wore that big smile as he lectured to us.

The United States Public Health Service can boast of two new members in the women's branch. The first of the new arrivals is Miss Lynn Susan Loebel, born to Dr. and Mrs. Arthur Loebel on September 5, 1945. Dr. Loebel is stationed in New Orleans. The second arrival is Miss Heather Tobis, daughter of Dr. and Mrs. Jerome Tobis. Dr. Tobis is also stationed in the south (Mississippi). Our heartiest congratulations to the mamas and papas of these new southern belles.

We had some very welcome visitors at School recently. Lieut. (j.g.) Paul Schmidt ('43) visited us while on leave, but not before he spent sufficient time getting acquainted with his 4-month-old baby son whom he saw for the first time. Lieut. Schmidt's next assignment is Pearl Harbor.

Captain Sylvan Surks gave us the low-down on his assignment in Europe, pausing long enough, however, to say how glad he was to be back in the good old U.S.A. Capt. Surks is now stationed at Camp Atterbury, Indiana.

Another welcome visitor was Lieut. (j.g) Irwin Halpert ('43) in his Navy Blues. Lieut. Halpert is an old sea dog by now and is at present stationed on the *U.S.S. Haida*.

**RECENTLY GRADUATED ALUMNI
WHO HAVE OPENED THEIR
PRACTICES**

Dr. Ralph M. Adelman, '43, physician and surgeon, at 3215 W. North Ave.

Dr. Roy A. Hecht, '43, physician and surgeon, at 6560 S. Western Ave.

Dr. M. Dee Shapiro, '43, physician and surgeon, at 3460 W. Lawrence Ave.

Dr. Nathan Subotnick, '43, at 1546 Shermer Ave., Northbrook, Illinois.

Dr. William H. Shlaes, '44, physician and surgeon, at 55 E. Washington St.

Dr. Herbert M. Smulson, '44, physician and surgeon, at 4403 Sheridan Road.

Dr. Leonard Tilkin, '44, practice limited to neuro-psychiatry, at the Woodlawn Clinic Bldg., 826 E. 61st St.

Dr. Marvin B. Wolf, '44, physician and surgeon, at 6103 W. Addison St.

To all these men may we take the privilege of wishing a very successful practice from the staff of *The Quarterly*, the student body, and the faculty. To those of you whom we haven't heard from as yet; we look forward to hearing from you. To all our alumni, if you have a spare moment send a 3-cent stamp our way and let us know how things are going with you.

* * * * *

**ALUMNI RECENTLY SEPARATED
FROM SERVICE**

(Taken from the Journal of the American Medical Association.)

December, 1945

Capt. Ben H. Barbour, Jr.	CMS 1940
Capt. John A. Guerreri	CMS 1934
Capt. Abraham Kushner	CMS 1933
Capt. Sheldon W. Reagan	CMS 1930
Capt. Elmer H. Schnicke	CMS 1936
Capt. Carmen Scudieri	CMS 1933

(Taken from the Chicago Medical Society Bulletin.)

December, 1945

Lt. Alex M. Berman	CMS 1936
Major August F. Daro	CMS 1925
Capt. Joseph Fireman	CMS 1936
Capt. Kenneth L. Fisk	CMS 1933

Capt. Bernard S. Freedman	CMS 1938
Lt. Louis B. Friedman	CMS 1939
Lt. Anthony J. Giacobe	CMS 1932
Lt. Seymour Hershman	CMS 1941
Major Jack D. Kirshbaum	Faculty
Capt. Franklin P. LeVan	CMS 1933
Lt. Alfred A. Munn	CMS 1933

(Taken from the Chicago Medical Society Bulletin.)

November 15, 1945

Capt. Norman S. Angel	CMS 1937
Capt. Thaddeus J. Chrzan	CMS 1941
Capt. Bernard L. Coniglio	CMS 1936
Lt. John M. Garnello	CMS 1936
Capt. Louis I. Greenspon	CMS 1935
Lt. Joseph H. Lieberstein	CMS 1937
Lt. Leo B. Lifchultz	CMS 1928
Lt. George Markoutsas	CMS 1940
Lt. Patrick Parisi	CMS 1935

Discharged (From Correspondence)

Capt. Charles L. Leach, Jr.	CMS 1941
Capt. Robert Adelman	CMS 1935
Capt. Herbert B. Erickson	CMS 1926
Lt. John Sharp	CMS 1937
Capt. Charles Morris	CMS 1940
Capt. Jacob M. Epstein	CMS 1939
Lt. Frank B. Warner	CMS 1941
Asst. Surg. (R) Harry F. Kaack	CMS 1943
Capt. F. Polsucki LeVan	CMS 1933
Capt. Isidore Brill	CMS 1936
Capt. James A. Calams	CMS 1939
Capt. David F. Jilyses	CMS 1930
Major Frederick Spector	CMS 1940

Released from Active Military Service

Besick, Anna A.	CMS 1929
Bowser, Albert W.	CMS 1936
Boykoff, Max O.	CMS 1937
Chardkoff, M. Austin	CMS 1931
D'Iorio, Philip J.	CMS 1936
Egel, Paul M.	CMS 1938
Guttman, Joseph R.	CMS 1926
Hootnick, Harry L.	CMS 1941
Hootnick, Jacques I.	CMS 1933
Jackson, Bruce E.	CMS 1926
Karabin, Andrew L.	CMS 1928
Kaufman, Saul D.	CMS 1938
Kearney, Richard D.	CMS 1935
Kessler, Charles T.	CMS 1934
Lodato, Victor	CMS 1940
Pachynski, Bernard L.	CMS 1934
Petrone, Joseph A.	CMS 1935

Pitzafro, John J.
Rosen, Isaac
Rottman, Morris M.
Saletta, Charles A.
Shapiro, Bernard
Shevin, Selig A.
Simonelli, Mario
Smialek, John M.
Steinberg, Fred B.
Zanette, Alfred A.

CMS 1934
CMS 1935
CMS 1928
CMS 1934
CMS 1935
CMS 1926
CMS 1934
CMS 1936
CMS 1934
CMS 1939

"Spots before the eyes" usually are shadows of white blood particles moving in the interior of the eyes to feed the tissues. Ordinarily the movement of these blood particles is not noticed, but when the eyes are tired or strained, says the Better Vision Institute, the visual nerves are so jumpy that they see the shadows which healthy eyes do not notice."

* * * * *

(Taken from the Chicago Medical Society Bulletin, December 22, 1945.)

Philip M. Baker
John Virgil Belmonte
Elder Lawrence Bolla
Kozme Francis Kapov
Harold M. Kass
Frank Lock
Albert Mizock
Walter Vincent Norak
Gervaise P. Pallasch
Charles Pava
Eli Rubens
G. James Sanfilippo
Thomas Slattery
Louis A. Wajay

CMS 1940
Faculty
CMS 1931
CMS 1940
CMS 1937
CMS 1926
CMS 1933
CMS 1935
CMS 1939
CMS 1932
Faculty
CMS 1938
CMS 1934
CMS 1938

We cannot adequately express our pride in the faculty and alumni of our school who have served our country so honorably and so well. They have proved to the world that our graduates can match other medical school graduates the world over in ability, valor and devotion to duty. For a job well done—we salute you!

* * * * *

NEW COMMISSIONS

Lt. (j.g.) Harry Barasch
Lt. (j.g.) William S. Easton
Lt. (j.g.) Irwin Halpert
Lt. Aaron E. Koblenz
Lt. (j.g.) William D. Larson
Lt. (j.g.) Stanley D. Rothman
Asst. Surg. (R) George Woloshin
Lt. Harold Zolan

CMS 1943
CMS 1943
CMS 1943
CMS 1942
CMS 1944
CMS 1944
CMS 1943
CMS 1943

ADVANCE IN RANK

Capt. Thaddeus J. Chrzan
Capt. Herbert V. Fine
Major A. A. Freedman
Capt. Joseph Liebross
Capt. Maurice Thaler

CMS 1941
CMS 1943
CMS 1940
CMS 1942
CMS 1940

Hal Koenig ('46) and wife, Ruth, had an addition to the family of one daughter, Susan, as of December 4, 1945. Dr. M. Netchow officiated at the Lutheran Deaconess Hospital.

The Donald Morrison Productions ('45) presented "It's a Girl," starring Leonette Sheryn Morrison, on January 10, 1946, at the Norwegian-American Hospital.

A. Abramowitz, of the Freshman class, married Miss Miriam Feldman on December 23, 1945.

Leonard Singerman ('49) of Oakland, California, was married to Miss Roselyn Glickman of New York City on December 29, 1945.

Herbert Lipschultz was married to Miss Jean Tucker during the past Christmas vacation.

Gerald L. Rabin ('46) will be married to Miss Annajean Kornblatt on June 23, 1946, at the Sheridan-Plaza Hotel.

Martin Werner, of the Sophomore class, will be married to Miss Phyllis Harris on March 3, 1946, at the Belmont Hotel.

Harold Grushkin ('49) was married to Rena Undank, September 30, 1945.

The Quarterly is pleased to extend the best wishes on their anniversaries to:

Dr. and Mrs. Herbert Smulson on April 4th.
Dr. and Mrs. Herbert H. Krautz on March 28th.
Dr. and Mrs. Philip Porter on January 1st.
Dr. and Mrs. Holden McCraney on December 29th.
Dr. and Mrs. Bernard Tumarkin on December 24th.
Dr. and Mrs. Meyer Shapiro on December 27th.
Dr. and Mrs. Louis J. Polskin on December 26th.
Dr. and Mrs. Ralph C. Rudder on December 25th.

Faculty Notes

PUBLICATIONS

P. P. Foa. The urinary excretion of Trigonelline and Nicotinic Acid-like substances in human subjects after the ingestion of Trigonelline and after smoking.

Meeting of the Chicago Section of the American Chemical Society, November 16, 1945.

J. A. Smith, P. P. Foa, and H. Weinstein. Toxic effects of large doses of thiamine.

November 28, 1945 meeting of the Chicago Section of the Society for Experimental Biology and Medicine.

P. P. Foa, J. A. Smith, and H. Weinstein. The effect of insulin on blood cocarboxylase.

1943 meeting of the American Physiological Society.

P. P. Foa. Chemical structure and Biological activity.

Insulin and Phosphorylation.

University of Illinois Physiology Journal Club.

J. A. Smith. The newer vitamins.

University of Illinois Physiology Journal Club.

* * * * *

It is with understandable pride that we of the Chicago Medical School welcome Dr. Howard H. Beard into our institution as Professor of Physiological Chemistry. The many fruitful years he has spent in biochemical research and pedagogy establish him as a significant adjunct to our faculty.

Dr. Beard has been fortunate in that his educational efforts and teaching affiliations have brought him before many sections of the United States. He is a native of York, S. C. After graduating from the University of South Carolina in 1914 he was for five years assistant state chemist in the S. C. Department of Agriculture. He received the M.A. degree in Chemistry under H. C. Sherman at Columbia University in 1921, and his Ph.D. in Biochemistry under the late Professor I. B. Mendel of Yale in 1925. He was Porter Fellow in Physiology at Yale in 1924, and assistant in medical biochemistry 1923-25. He was appointed Instructor in Biochemistry, School

of Medicine, Western Reserve University, Cleveland, Ohio, in 1925 and was acting head of the department for two years. In 1931 he was called to the chair of Biochemistry at the newly formed Louisiana State University School of Medicine in New Orleans.



Dr. Howard H. Beard

In spite of the hot weather and sociability of the city of New Orleans, he found time for much research work in the fields of nutrition, biochemistry, cancer, muscle metabolism, etc., since over 120 of his papers have appeared in different scientific journals. He was finally successful in arranging the 1940 meeting of the Federation of American Societies of Experimental Biology in New Orleans when the new Charity Hospital was dedicated. As vice-chairman of the Louisiana State Nutrition committee he was very active in looking after the nutritional needs of many of the poor people in the distant parishes of the state. He was also chairman of the Committee on Food Enrichment and obtained passage of the bills enriching flour, bread, and oleomargarine with vitamins and iron. Louisiana was the second state to pass these laws, following the example set by South Carolina. At the present time about 10 states have passed this much-needed legislation.

Some of his more recent papers include the following:

Beard, H. H. Some recent trends in experimental cancer research. *Exper. Med. & Surg.*, 11, 129-143, May 1944.

Beard, H. H. Effect of penicillin and choline upon the

appearance, growth and regression of the Emge sarcoma in rats. *Exper. Med. & Surg.*, 11, 286, 1944.

Beard, H. H. and Theodore J. Dimitry. Some observations upon the chemical nature of the ptygerium. *Am. J. Ophthalmology*, 28, 303, 1945.

Dimitry, Theodore J. and Beard, H. H. The story of choline chloride in relation to clinical medicine with special reference to urology and dermatology-Urologic and Cut. Rev., 48, 91, 1945.

At the present time Dr. Beard is engaged in research dealing with the production of certain steroids in the urine of cancerous patients. He is attempting to obtain a urinary alcoholic extract of the steroids which will produce diagnostic changes on injection into mice.



Dr. Beard at work in his new laboratory

Dr. Beard is a member of the following societies:

American Society of Biochemists
American Chemical Society
American Institute of Nutrition
American Institute of Chemists
American Association for Cancer Research
American Medical Association (Associate Member)
Louisiana Academy of Sciences
New Orleans Academy of Sciences (twice Vice-President)
Louisiana State Nutrition Committee (Vice-Chairman, 1941-46)

Sigma XI (Yale) and Omega Upsilon Phi (Penna.)

Dr. Beard is married and his family includes one son and daughter. Unfortunately, his family is still down in Louisiana as a result of some unsolved housing difficulties. We hope this problem soon resolves itself, Dr. Beard, and that you will find your new appointment at the Chicago Medical School as enjoyable as we will find it instructive!

* * * * *

All men are the same and our progress is purely exterior, mechanical and material. The great revolution — the one within — has not yet arrived. It was begun by Christianity but without result, because no Christian practices its teachings.

—Ibanez

* * * * *

Etienne Marey, a French physiologist, in 1876 was the first person to devise an instrument for measuring and recording blood pressure.

Through the survival of their children, happy parents are able to think calmly, and with a very practical affection, of a world in which they are to have no direct share.

—Walter Pater

* * * * *

Perpetual Holiday

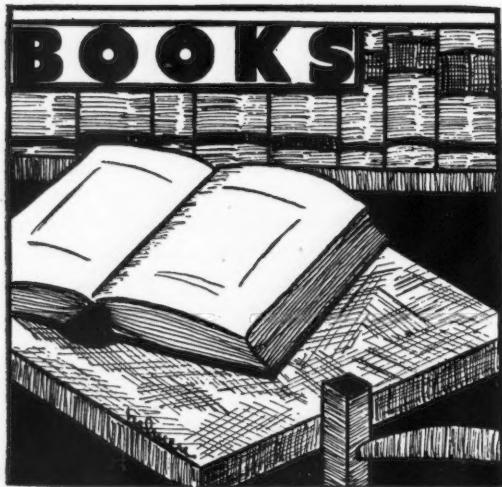
Obstetrician Cotterson
Is working day and night
So that someone's daughter, son
Or twins will "turn out" right!
So the cry, "It's Labor Day!
A holiday, by gee!"
Makes the Doc yell, "Ev'ry day
Is labor day with me!"

—B. C.

* * * * *

He who is allowed to take the start of his species, and to penetrate the veil which conceals from common minds the mysteries of Nature, must not expect that the world will be patiently dragged at the chariot wheels of his philosophy. Mind has its inertia as well as matter; and its progress to truth can only be insured by the gradual and patient removal of the difficulties which embarrass it.

—Sir David Brewster



THE WAY OF AN INVESTIGATOR. By Walter B. Cannon. A Scientist's Experiences in Medical Research. 1945. Norton. New York. \$3.00

In this book Dr. Cannon, dean of American physiologists, a great teacher, brilliant investigator, public-spirited liberal, and world leader, tells something of his working principles.

Born in 1871 at Prairie du Chien, Wisconsin, where in the 1820's William Beaumont made his pioneer digestion observations on Alexis St. Martin, Cannon worked his way through Harvard College, graduating *summa cum laude*, and later through the Harvard Medical School. "A valuable result of the pressure on time was the discipline it demanded in ways of working. I had to learn to concentrate on the essentials of the task in hand and to finish it rapidly and accurately."

For forty-one years Dr. Cannon taught in the Harvard Medical School, and for thirty-six years he was head of the department of physiology. He summarized his classic researches in four books for the general public, viz: *Bodily Changes in Pain, Hunger, Fear and Rage*; *The Wisdom of the Body*; *Digestion and Health*; and *Traumatic Shock*, the last, a result of his experience and researches in World War I.

More than half "The Way of An Investigator" is devoted to discussions of: research, fitness of the enterprise, favorable and unfavorable circumstances, the role of hunches, fellowship in exploration, when scientists disagree, some work-

ing principles. These chapters will well repay careful study.

Endowed with remarkable vitality, Dr. Cannon was not only a tireless investigator and inspiring teacher, but a zealous citizen. For seventeen years, as Chairman of the Committee for the Protection of Medical Research, he led the fight against the efforts of the anti-vivisectionists to pass hostile bills in the legislatures of various eastern states, in Congress, and in popular referenda in Colorado and California (p. 159). He became deeply interested in the Spanish Republic and served as national chairman of the Medical Bureau to aid Spanish Democracy. "Experience in China as a visiting professor at the Peking Union Medical School, in 1935, revealed . . . a situation which resembled that in Spain in 1930." He aided in the American Bureau for Medical aid to China and in United China Relief. Pavlov was one of Cannon's many friends. "He and other Russian scientists were as kind, considerate, and generous as any I have known. The vast social effort in which they were engaged was different from that in which I placed my trust, but it was directed toward bettering the lives of their fellow citizens." He became president of the American-Soviet Medical Society.

He emphasized the fact that democracy must be vigilantly protected. And, this "has a direct bearing on the role of the scientific investigator as a citizen. The unchecked pursuit of his most cherished desires depends immediately on the liberty which a democratic government provides. He does well, therefore, to watch over it, and, if necessary, to go forth from his 'serene attachment to the processes of inquiry and understanding' to battle for its security." (p. 165)

"The Way of an Investigator" gives us the ripe wisdom of a scientist with extraordinary vision and ability to achieve, who lived life with zest and who possessed a great love for his fellow men.

L. B. Nice

* * * *

TRENDS OF MENTAL DISEASE — American Psychopathological Ass'n, 120 pages, King's Crown Press, Morningside Heights, N. Y. Dec. 1945.

The commonly heard expression of opinion that there is an appallingly enormous increase of

mental disease in our burdened modern life, has led the authors of this book, through the American Psychopathological Association, to cooperate in a symposium to get the facts of the situation and interpret them statistically.

The introduction to this work immediately reflects the difficulties encountered in a complexity of factors. It is necessary to rule out the effects of increase of longevity per se, as well as newer more adequate and more widespread diagnostic procedures in use today together with the general increase which is progressively developing in institutional accommodations for the mentally ill. This situation is aggravated by the scarcity of reliable statistics upon which interpretations can be accurately based. In spite of these handicaps, the authors have succeeded admirably in making a fine start toward solution of this formidable problem. The book is divided into three sections which consider respectively: future trends, current trends, and the effects of war in the mental disease picture.

It is difficult to make a general statement of conclusions from these facts and the reader is invited to draw his own, but a summary may be attempted briefly here. The outlook from 1940-2000 in the United States is dependent upon the expected population changes in that period. These expectations are (1) a progressively decreasing rate of increase in population, and (2) a marked change in age composition affecting principally a marked rise in the older working force and a virtual doubling of the proportion of persons 65 years of age and over. On these bases there would be an increase of about 90% in 2000 over the number of hospitalized patients in 1940, this increase being due dividedly to: growth of population, 23%; aging, 35%; and improvements of hospitalization facilities, 42%.

In national census statistics between 1936 and 1942, it was found that there was a definite increase among first admissions to all hospitals in the proportion of persons diagnosed as with cerebral arteriosclerosis and a decrease in those with manic-depressive psychoses; all others showing relative constancy. Differences between statistics of New York State and Illinois show the results of an unfortunately unstandardized method of report for comparison. All of these indicate, however, an increase in mental disease which is especially effected by the larger number

of geriatric patients with senile psychoses, due to advancing medical success in bettering the physical health of the nation and the accompanying increase of average life expectancy. The functional psychiatric conditions, however, in which added life burdens should play the important role, significantly failed to be appreciably changed.

Naval psychiatry is summarized very well and the following facts concluded: (1) military psychiatric problems are unique and thus statistical comparison with civilian records is not wholly valid, (2) inadequacy to meet military standards does not necessarily mean inability to adjust to the less demanding situations of civilian life, and (3) actually about 90% of those accepted and later discharged by the Navy for emotional inability and inadequacy should adjust well to civilian life.

The experience of the selective service system in World War I has been of great aid in avoiding pitfalls for the recently terminated conflict. This shows itself very well in the figures cited which show that since the rejection rate for the latter war was 5 times as high as for the former, the great difficulty with mental disorders experienced by Pershing's troops has not been repeated.

This book is definitely recommended to all those interested in this very important subject as a concise, accurate, and well-presented symposium. To the medical practitioners and students, a comprehension of the trends suggested in this book is imperative for a proper viewpoint of the public health problems of today and tomorrow.

* * * * *

DEMONSTRATION OF PHYSICAL SIGNS IN CLINICAL SURGERY. By Hamilton Bailey, Williams and Wilkins. Baltimore, 1944. Ninth Ed., 351 pp. \$7.00.

A truly fine medical book is Bailey's book on physical diagnosis of surgical conditions. In it, this famous English surgeon vividly demonstrates by means of drawings, photographs, and an unusual amount of excellent colored photographs, useful clinical signs in surgery.

The best way of learning physical diagnosis is by seeing the physical examination done by excellent clinicians, and then, by actually eliciting the important signs by oneself under the

guidance of the clinician. This is the object of our clinics. No person can learn how to diagnose from purely didactic and descriptive texts. The most that may be learned from such texts is the rationale and the theory with which one may later integrate his clinical experience.

Bailey's book, however, is not such a text. The words are not theoretical expositions of the manifestations of disease processes. They are explanations and directions such as one might receive from a skilled surgical diagnostician who is demonstrating physical signs at the bedside. What is more, you can see exactly what the surgeon means, with the aid of 492 excellent illustrations.

Reading this book is almost as if one were making ward trips with Doctor Bailey. It is not quite the real thing, but it is the closest of any text I have seen, to the reality of the clinic. I strongly recommend it.

E. C.

* * * * *

BENADRYL—

(Continued from page 6)

Several patients with marked asthmatic attacks were given Benadryl without noticeable effect.

So far the effects have been dramatic in acute and chronic Urticaria, Angio Neurotic Edema and Serum Sickness. Since an anti-histamine drug seems to be effective in controlling Urticaria it may be assumed that this is additional evidence that histamine is a factor in its production.

The drug seems to have a wide margin of safety and the only toxic manifestations noted were drowsiness and muscular aching. The occurrence of these untoward symptoms indicates too large a dosage and it may be best to reduce the dose when these toxic symptoms occur. They also promptly disappear when the drug is discontinued.

Further clinical and laboratory studies over a long period of time are required, in order to determine the possible status of this drug as to toxicity on the bone marrow, reticulo-endothelial system and central nervous system.

The drug has not been released to the medical profession and its use is still in the experimental stage until further data is obtained. It seems to be the most effective drug to neutralize

the effects of histamine in the body that has so far been discovered.

References—*Essentials of Clinical Allergy* by Samuel J. Taub, M.D. F.A.C.P. Published by Williams and Wilkins Co. Baltimore, Md. 1945.
"I wish to thank Parke Davis and Co. for kindly furnishing me with "Benadryl" for experimental use.

6 North Michigan Ave.
Chicago 2, Illinois

ETHICS—

(Continued from page 5)

with honesty, justice, and above all mercy, as guiding lights along our way.

* * * * *

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* * * * *

CONCERNING THE DANGERS THAT BEFALL

INNOCENT ANIMALCULES

Willus the Bacillus
(The textbook doth tell us)
Was merrily wending his way;
With a flagellate motion,
He swam in the ocean
Off the island of Peyer's patche'.

Gamboled he sprightly,
The current him lightly
Placed on that receptive isle;
So he shook from his butt
The contents of the gut;
And entered the joint with a smile.

Met him, "Good Morning,"—
The lymphocytes storming—
Attacked him with hammer and flail;
Squeezed him and kicked him,
Bit him and nicked him,
And swung him around by his tail.

MORAL: Each little bacillus
Must learn from our Willus
What yes and what not he must do.
The jub-jub that snatches
Doth live in the patches—
So stay away from them or else
It may happen to you.

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N. E. Cor. Harrison & Honore



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* * * * *

A wise man is one who puts all his eggs in one basket and then watches that basket.—Mark Twain.

"TAKING THE HISTORY"



"WHAT CAN A SICK MAN SAY, BUT THAT HE IS SICK?"

SAMUEL JOHNSON

Letters to the Editor

The following letter was received by the Editor for publication in *The Quarterly*:

December 13, 1945

Dear Mr. Malitz:

I was invited by Dr. Gustav Bucky, the inventor of the Grenz-rays, Bucky rays or Super-soft rays to deliver a lecture about the use of the Grenz-rays in skin diseases, in which I had experience of over twenty years, and to participate in a conference with military authorities who planned to introduce the Grenz-ray treatment of skin diseases into the Army.

I left Chicago for New York, Thursday, November 22nd, had a conference Friday at 2:00 P.M. at the Bellevue Hospital. We had dinner with Dr. Bucky, Dr. Otto Loewi, the Nobel prize winner, Dr. Lilienfeld, the X-Ray physicist, Dr. Combes, Professor of Dermatology at Bellevue, Major Lingood, M.C., sent by the Surgeon-General to collect experiences about Grenz-rays, and others. After dinner a conference was held which lasted until 12:00 P.M. Monday morning I visited the Seaview Hospital at Staten Island, where Dr. Bucky treats tuberculosis with general exposures with Grenz-rays. At 8:15 P.M. that night, I delivered my lecture. Dr. Lilienfeld, who introduced the total vacuum for the x-ray tube, delivered a lecture about Grenz-rays from the physical point of view. After the lecture a discussion took place until 12:00 A.M. at which Drs. Combes, Lilienfeld, Reiss, and many others attended.

Tuesday evening I left New York with the feeling that I had accomplished a little bit to propagate the use of Grenz-rays in Dermatology.

Maurice Oppenheim, M.D.
Professor of Dermatology and Head
of the Dermatological Department,
Chicago Medical School.

* * * *

December 22, 1945

To the Editor of the *Quarterly*:

Dear Sir:

I do hope you will keep me on the mailing list now that I'm back at my old post.

Enclosed find a copy of Ship's paper which contains a note on one of the many experiences I had on my job as transport surgeon.

With best wishes for continued success.

LeRoy P. Levitt, Capt. M.C.
Class '43

Editor's Note: Herewith is the copy of Capt. Levitt's ship's paper:

EMERGENCY OPERATION

While the Thanksgiving turkey was going under the knife for your holiday feast, the skillful scalpel of Captain LeRoy P. Levitt, troops surgeon, was performing a delicate emergency appendectomy on one of the homeward bound G.I. passengers on the *Monticello*.

Pfc. Joseph T. Makowski of the 480th AAA Bn., a 73-pointer from Pittsburgh, reported to Sick Bay, Thursday noon, where his "indigestion" was diagnosed as acute appendicitis. At 1700, blessed by comparatively tranquil sea and assisted by Lt. Cmdr. A. A. Doerner, ship's surgeon, Capt. Levitt performed the operation. This morning Pfc. Makowski, his appendix bottled and his appetite increasing, was looking forward to seeing his wife, his three-year-old daughter, and a home-cooked turkey to make up for the one he missed.

The emergency operation was no novelty to the two surgeons for they had already performed a similar one on the *Monticello's* eastbound trip last week. — From *USS Monticello Ship's Paper "Homeward Bound,"* Vol. 1, No. 5, November 24, 1945.

* * * * *
October 18, 1945

Gentlemen (and Ladies) of the *Quarterly* Staff:

At long last—a venerable and bearded alumnus of the Staff returns with word of his whereabouts and doings in lo, these many moons.

Graduation in 1943 saw me very comfortably esconced in a lush internship at the Bronx Hospital in N.Y.C. Brilliant (natch!) work resulted in surgery residency at same place. Thus 18 months crept by on their "petty paces" and I was given the job as Ward Surgery Resident or House Surgeon—again at Bronx Hospital (getting into a rut, what?) However, the U. S. Navy deemed it imprudent—and that ain't all—for me to be a civilian—or is it "feather merchant"?—and so in July 1945, I began MC. USNR, rank of Lieut. (j.g.). Some duty with the Seabees did the chore of house-breaking me into naval routines and procedures and on October 8th, I reported aboard the *U.S.S. Stormking*, which is a navy transport. All this via San Francisco, San Diego, San Pedro, Manila, Pearl Harbor, Honolulu and finally aboard, about Honolulu. Let it suffice for me to say merely that disillusionment comes quickly to the young in heart and easily impressionable such as I. Ditto for the highly-touted Waikiki. Nothing at all attractive about either place.

That brings me up to date—and our next trip is to Japan or China to pick up about 1600 more POW's from prison camps.

I had gotten the *Quarterly* at Bronx Hospital as regularly as you guys sent it—quite good—and a nicely done job all around. Keep it up, and please, please send me my *Quarterlies* regularly to the ship I am on now. Thanks.

Sincerely,

Daniel C. Belden, Lt. (jg) MC USNR

P.S.: You could print this in "Letters to ye Editor" if you like. I wouldn't mind being in print again. Would thrill these jaded senses.

* * * * *

November 17, 1945

Editor: The *Quarterly*

Dear Sir:

Thank you for the recent issue of the *Quarterly*, and congratulations to you and your staff for your excellent work in making the periodical so interesting and informative.

One issue reached me while I was a patient at the Jewish Hospital in St. Louis, Missouri in August. It was doubly welcome at that time.

Since resuming my practice in October, I was elected Secretary of our Staff at St. Elizabeth's Hospital in Granite City, Illinois. Was certainly happy to get back to the old "grind" and don the "harness."

I recently heard from two of my classmates, Capt. Bernard Schwartz and Capt. N. E. Lanoy. The former served in Hawaii and Okinawa, and the latter in Germany. We are looking forward to seeing them soon, possibly in their civies.

Keep up your good work.

Sincerely,

J. K. Chalfin, M. D.
Class of 1935

* * * * *

January 10, 1946

To the Editor of the *Quarterly*:

Dear Sir:

In my Army wanderings I had no difficulty losing contact with your journal and through it with the source of my medical training. I admit being derelict in my attentions and my forwarding of funds and this is attributable in great part to preoccupation with the vicissitudes and demands of the Army. However, I shall be glad to make up for this neglect if you will indicate how I may again receive the *Quarterly*.

At present I am stationed at this lavish medical center and continuing my pre-Army work in neurology. Although I have functioned as a neuro-psychiatrist throughout my Army career, this is the most fortunate assignment since it is a neurologic and neuro-surgical center, and hence relatively replete with brain and cord tumors, aphasias and the rare and usual infectious, traumatic, and degenerative diseases of the nervous system.

I am looking forward to hearing from you and hope that you will be able to incorporate in your communication any official or semi-official developments relative to the school.

Sincerely yours,
Louis Berlin
Capt. MC

* * * * *

January 14, 1946

To the Editor of the *Quarterly*:

Dear Sir:

The Board of Trustees and the Library Committee thank the Editorial Board of the *Quarterly* for their recent gift of:

AMER. PSYCHOPATH. ASSN. TRENDS OF
MENTAL DISEASE, 1945

This will be placed in the library as soon as catalogued.

Yours very truly,
Marguerite E. Campbell

* * * * *

"COURAGE AND DEVOTION BEYOND THE CALL
OF DUTY"

Through the co-operation of Mead Johnson & Company, \$34,000 in War Bonds are being offered to physician-artists (both in civilian and in military service) for art works best illustrating the above title.

This contest is open to members of the American Physicians Art Association. For full details, write Dr. F. H. Redewell, Secretary, Flood Building, San Francisco, Cal.

The THYMUS has puzzled us all,
We don't understand it a-tall;
Most scientists shout
What the gland is about,
But their words are a sham and a stall.
The PINEAL gland is a dandy,
Which doctors so dutifully bandy
Around till a coma
Suggests a psammoma.
Which simply means "now it is sandy."

Abstracts

THE MARCH OF MEDICINE; THE NEW YORK ACADEMY OF MEDICINE LECTURES TO THE LAITY, 1944. Columbia University Press, N. Y., 1945.

"The pen (so springs the constant hope
Of all devout physicians)
Is mightier than the stethoscope,
And runs to all editions.
So while he's waged bacillie wars,
Or sewed a clever suture
His mind has hummed with metaphors,
Laid up against the future."

With the spirit of the medical poet, Dr. Harold Ruckman Mixsell, writes the introduction to this very readable collection of **Lectures to the Laity; 1944.**

Began nine years ago, this annual series has endeavored to "reveal to the laity the philosophical background of the healing art, the historical perspective of public health, the illumination of the horizons of science and the relationship between medicine and the collateral sciences of sociology, criminology and economics . . . to keep the public informed of recent medical discoveries with an insight into the trends of medical research and to produce a oneness of purpose in all the ramifications of the effort toward the betterment of man."

The ninth series was entitled "War and the Expanding Frontiers of Medicine," and has produced six lectures by eminent authorities which are well worth reading . . . particularly by medical men. The simplification and the approach of these lectures do much to clarify the social objectives of their specialties.

The lectures included: "Morale and Propaganda," by Edward A. Strecker, M.D.; Charles Glen King, Ph.D. on "Food and Civilization"; "The Past, Present, and Future of Chemotherapy," by Colin M. McLeod, M.D.; "Medicine and the Changing World," by Reginald Fitz, M.D.; "The Effect of Science Upon Human Beings," by Sir Gerald Campbell; and "Wars and Epidemics," by Lieut. Col. Thomas T. Mackie, M.C.A.U.S.

All of these discussions are written in an in-

formal authorative style, and do much to clarify the broader implications of medical progress.

E. C.

* * * *

FOUNDATIONS OF NEUROPSYCHIATRY. By Stanley Cobb. Williams and Wilkins, Baltimore, 3rd ed., 252 pp. \$2.50.

Neurology is a very large and complicated field. It involves a study of the complete anatomy, a sometimes apparently illogical physiology, and a clinical knowledge that may seem to contradict both anatomy and physiology. Of course, we know that no objective clinical finding will ever really contradict the reality of exact anatomy and physiology, but unless one is able to integrate the full anatomic and physiological truths, clinical findings may seem to point unnatural pathology . . . Particularly in neurology.

Dr. Cobb, a man well qualified to discuss neurology from any angle has written a book which serves the very important purpose of summarizing the important anatomical, physiological and pathological realities of neurology, and which integrates these with the clinical findings. In addition, he very ably (even if somewhat sketchily) deals with the basic mental and psychiatric phenomena.

The entire book is excellently written, but I find that the chapters on Motor Integration and Locomotion, and General Neuropathology are particularly well integrated and give lucid explanations for what may well be very confusing topics.

The book was written with the object of giving the starting student an orientation toward neurology and psychiatry, but even a graduate student will benefit by reading this simple, revealing book.

E. C.

* * * * "

THE REASON so many retired men die mentally is because they stop doing everything they do not want to do. When they do that they also stop growing. Growth is a result of assuming obligations and responsibilities. Retirement is too often a state of slow decay and death. The minds of too many retired men become stagnant pools.

—Thomas Dreier

MR. LIEBERMAN—

(Continued from page 21)

Member of the Executive Committee,
United Jewish Appeal

Member of the Board, Joint Defense Appeal

The most recent of Mr. Lieberman's national interests is the Chicago Medical School, and we are happy to have him interested in and working for our cause.

Mr. Lieberman's membership in Philadelphia organizations are too numerous to mention in full, so we will list just a few here:

Honorary President, Jewish Welfare
Society of Philadelphia

Vice-President, Philadelphia Allied Jewish
Appeal

Treasurer, Philadelphia Jewish Community
Relations Council

Member of Board, United War Chest of
Philadelphia

Earlier this year, Mr. Lieberman was elected to the Board of Trustees of the Chicago Medical School. We, of the School, welcome him most heartily. His experience and counsel will be of great value in guiding the future course and progress of our institution.

* * * * *

MR. SUGARMAN—

(Continued from page 21)

ecutive Committee of the Zionist Organization of America out of its Policy Shaping Committee. In 1946, he was elected President of the Borough Council of South Coatesville, Pennsylvania. His other civic activities include membership on the Board of the Boy Scouts of America, Interracial Organizations, and in addition he is noted for his philanthropic services.

Mr. Sugarman married Ida Barasch of Brooklyn, New York. Their son Dr. Leroy A. Sugarman graduated from the Long Island College of Medicine and is now interning at the Montefiore Hospital in New York City.

On behalf of the students and faculty the *Quarterly* takes pleasure in welcoming Mr. Sugarman to the Board of Trustees of the Chicago Medical School.

THE TIME TO
CONTRIBUTE
IS NOW!

Don't Forget our

**ENDOWMENT
DRIVE**

FOR **YOUR** SCHOOL
FOR **YOUR** EDUCATION
FOR **YOUR** STANDING

**SUPPORT THE
ENDOWMENT
DRIVE**

~~~~~

Dear Alumni:

*We are really very modest—*

but it is no use denying that we are very pleased with, and slightly proud of, the way you have received the QUARTERLY. Your letters have been unanimously complimentary, your comments heart-warming. We thank you.

Especially do we derive deep satisfaction from supplying to you who are in the armed forces the measure of diversion and enjoyment that you have told us the QUARTERLY brings you. We intend to get the QUARTERLY to you, wherever you are, if it is at all possible, and whether or not you are active subscribers. Thus, we may feel that we are helping you, in a very slight way, to do the grand job that you are doing, at and behind the fronts.

But the QUARTERLY cannot be published with good wishes alone. We ask those others of you, who are fulfilling the equally important task of maintaining civilian health, to support this publication so that it may continue to bring you and our graduates in the service into closer touch with The School and each other.

Sincerely,

The Editor

I hereby enclose (a check for) \$..... (1 year's subscription, \$3.00)  
(2 year's subscription, \$5.00)

Dr..... Class of .....

.....  
.....

O DREAD COMPLAINT!

L. W. Tannenbaum

Since medic studies I've begun,  
Dat debbil illness spoils my fun;  
As with assignment I keep pace,  
Strange maladies I needs face.

My Cecil, which I read each night,  
Describes my symptoms with delight—  
Symptoms, signs, physical findings,  
Shooting pains—but sometimes grinding.

NOW to describe my Chief Complaint  
Is but a notion slightly quaint.  
Stridor, harsh on inspiration—  
All the signs of inflammation.

Pain, tenderness, loss of function,  
Tabs, pulvilli, mayhap unction?  
Dyspnea, amenorrhea,  
Meningitis, gonorrhea.

Alternating constipation—  
Interesting speculation.  
Uremia, and nephritis,  
Girlish vulvovaginitis.

Schizophrenia, psychosis,  
Psychosoma and neurosis.  
Coryza, 'flu, or rhinitis.  
Emboli (thrombophlebitis).

Simple, compound, septic fractures,  
God forbid—Volkmann's Contractures!  
Dislocation! D D a sprain—  
You'll never make it, you've no brain!

Will all these worries never cease?  
God, let me study now in peace.  
Fix the Philco so it's quiet.  
Maybe I'll try Sippy's diet.

Since I've kept pace with latest text—  
God, what assignment will be next?  
Such an all-inclusive list,  
Guess I'll call a specialist.

• • • • •  
Medicine is the most powerful, politically, of any scientific activity. If it follows education into the political maw there will be little to prevent all other intellectual activities and freedoms from following. It is imperative, therefore, that freedom of scientific action, speech and criticism be insisted upon quickly by all scientists, both for medicine and for themselves. The mind is greater than the body. Habeas Corpus was one milestone in human freedom; Habeas Mentem must be made the second.

—Bourne—Brit. M. J.

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